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ABSTRACT

Presented are detailed reports of eight child abuse and neglect programs, and a synthesis of the information obtained through onsite visits to programs and a review of the literature. Provided in Part I are the descriptive case studies of two hospital-based programs (Children's Trauma Center, Children's Hospital Medical Center, Oakland, California, and the SCAN Program, Pittsburgh Children's Hospital, Pittsburgh, Pennsylvania), two private nonprofit agency-based programs (Bowen Center of the Juvenile Protective Association, Chicago, Illinois, and SCAN Volunteer Service, Inc., Little Rock, Arkansas), two public social service agency-based programs (Hennepin County Welfare Department, Minneapolis, Minnesota, and Lehigh-Northampton Counties Coordinated Child Abuse Program, Pennsylvania), and two community-based team programs (Billings Child Abuse and Neglect Community-Based Team, Billings, Montana and Laramie Child Abuse Council and Treatment Team, Laramie, Wyoming). Part II on themes and issues in child abuse and neglect presents chapters on the following topics: criteria and definitions, case reporting and incidence; characteristics and dynamics of abuser/neglecters; characteristics of the abused/neglected child; identification, case management, and treatment; social services health, child care, educational, and law enforcement systems; and conclusions and recommendations. (IM)

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CHILD ABUSE AND NEGLECT PROGRAMS: Practice and Theory

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
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National Institute of Mental Health
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We also extend our warmest thanks to the directors and staff of the programs visited who spent a great many hours sharing their ideas and experiences with us. We appreciate their time, their efforts, their concern, and their support for this project. Many of the ideas expressed in this document are an outgrowth or a synthesis of ideas developed by these individuals.

Monica B. Holmes, Ph.D.
Project Director

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FOREWORD

The phenomena of child abuse and neglect are not new. What is new is that they are now seen as worthy of public and professional concern. Child abuse is no longer a family issue but a social one.

In a manner comparable in philosophy with the societal response to perceived child interests manifested in the compulsory education laws that began emerging 150 years ago and the child labor laws of 75 years ago, we as a Nation have begun to carefully set the limits of physical and emotional parent-child interaction. We have reached a point in our social history when going beyond those limits invites involvement in the family by the full range of society's institutions.

Our social service systems have, by and large, taken on the ombudsman role in coordinating the responses of the various institutions. Political institutions have defined the general limits of parental authority; they have facilitated the reporting of identified abuse and neglect; and they have defined the legal response. Medical institutions have given a clinical context for abuse and neglect by providing diagnostic criteria and establishing a response to the physical manifestations of abuse and neglect. The police and courts have provided the machinery to enable preventive and authoritatively controlling interventions.

The tough role—that of change agentry *vis a vis* the family—has devolved upon the mental health system. It is tough because it is not directed at adapting to what is, but working toward what might be; it is the step beyond defining, identifying, punishing, reacting. It calls for facilitating sufficient change in individuals and families to create, at the very least, a safe environment (and, hopefully, a nurturing one) for a child to grow up in. And this sort of intervention is hard work. People involved in this effort need organized support and direction.

A wide range of possible programmatic responses directed toward therapy exists, but is not being utilized to the fullest. This publication provides descriptions of some programs as examples of what can be accomplished. By looking at what eight communities are currently doing as a response to the need for treating the families of child abuse, the Holmes' report offers guidance to planners, administrators, and clinicians who are, or are planning to be, part of the change agent response to child abuse.

Child abuse is an unbelievably common problem. At least 6 out of every 1,000 children now being born will suffer from it. And yet, child abuse is one of those common things that has the power to shock most of us each and every time we come into contact with it or hear about it. It is in emerging from the shock that the pain is felt and the urgency to not just repair the ills but prevent future harms and strengthen both child and family is manifest. This publication can provide some direction for that heartfelt urgency.

Bertram S. Brown, M.D.
Director
National Institute of Mental Health

INTRODUCTION

This document on child abuse and neglect is presented in two parts. Part I presents eight program case studies; part II is a synthesis of what has been learned both from the literature and from the site visits to the eight programs.

Most of the published literature in the field focuses on characteristics of abusive/neglectful families and on issues related to reporting and nonreporting of cases. There is relatively little literature which deals with the "state of the art" in terms of program planning, case management and treatment, and the roles of various agencies within that context. The primary intent of this work is to take a first step toward filling this gap.

This work is addressed to program planners within community mental health centers, child guidance clinics, public and private family and social service agencies, and hospitals. It is also intended for practicing clinicians and social service staff and their supervisors as a training tool to encourage case discussion and ongoing efforts to improve therapeutic skills.

The eight programs described in part I represent a remarkable diversity in terms of communities, auspices, services, operations, relationships with other agencies in their communities, and styles and philosophies of treatment. We hope that planners will examine the programs described and will draw conclusions as to possible changes or additions that can be made within their own settings to improve existing programs or to develop programs where these do not currently exist. In other words, the eight program case studies are designed to draw attention to possibilities and opportunities for program creation or improvement.

The sections on case management and treatment presented within each of the program case studies provide detailed reports on the treatment of actual cases. These cases can be used by program staff as a springboard for discussion regarding management and treatment alternatives. It is our hope that clinicians not currently serving abusive and neglectful families will use the case materials and the program models as a starting point for the development of responsive services. Effective management of child abuse and neglect requires input from many disciplines. Mental health professionals have invested little in this field, and, as a result, treatment services are markedly underdeveloped. Our plea to these professionals is that they become involved because child abuse and neglect are important mental health problems which require their best efforts and because a large proportion of these families can be helped with appropriate intervention.

In selecting programs, Community Research Applications, Inc. (CRA), staff sought to obtain as wide a range of programs as possible. As a first step in the selection of programs, we wrote to the State Department of Mental Hygiene and/or of Social Services in each of the 50 States, also asking professional colleagues and experts in the field to give us names of programs maintained under mental health auspices or programs in which there was a particular emphasis on treatment. Among programs thus identified, we selected only those which had been in existence for a minimum of 2, and preferably 3, years and programs which serviced a minimum of 25 families.

Each of the programs was site-visited for up to 1 week by the project director, a clinical psychologist, and by a program analyst. The project director interviewed supervisors and all of the treatment staff in some programs or a maximum of 10 in the larger programs. The focus of these interviews was on presentation of treatment cases, especially the treatment process and techniques. In addition, the project director was present at a case staffing or at a clinical case conference at all but one of the programs and in some programs was present at several such conferences. The program analyst conducted

interviews at approximately 10 community agencies with which the child abuse and neglect program maintains joint service planning or referral linkages. In most communities agency interviews were conducted in at least one hospital, in the public social service or child welfare agency, in at least one mental health and/or child guidance clinic, in the public health agency, and with law enforcement officials including the police, probation official, county attorney, juvenile court judges, and neighborhood lawyers. Additional interviews were conducted with staff from other programs providing child abuse services and with university-based individuals providing consultative services to abuse programs. Finally, the project director and the program analyst collected data regarding program funding, operations, staffing pattern and, when possible, data on the characteristics of participants.

The programs described in part I represent four different auspices. There are two hospital-based programs; two private, nonprofit, agency-based programs; two public social service agency programs; and two community-based team programs. We have chosen to present the programs in these pairings by auspice category in order to highlight the diversity within even a single "model." Each two programs operating under a single type of auspice are introduced with a brief statement which highlights their differences in approach and emphasis.

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PART I
CHILD ABUSE AND NEGLECT PROGRAMS: EIGHT DESCRIPTIVE PROGRAM CASE STUDIES

In the case studies which follow, the names of all clients have been changed to preserve the privacy of the individuals who have participated in these programs.

Chapter I – Hospital-Based Programs

INTRODUCTION

The two program case studies which follow deal with hospital-based programs. Both programs illustrate the fact that hospitals are most likely to see abused children 0-3 years of age and that older children are seen less frequently. Both programs are based in children's hospitals in large metropolitan cities. However, whereas the SCAN program in Pittsburgh operates primarily to ensure identification and reporting by hospital staff, the Children's Trauma Center in Oakland, California, is a separately funded child abuse program which is designed to do all that the Pittsburgh program does *and* to provide comprehensive treatment and supportive services to families identified in the hospital. Both programs demonstrate the value of a hospital team which raises consciousness about possible abuse; provides training, consultation, and support to professionals; and makes a first contact with parents in a supportive and therapeutic manner. Both programs illustrate the remarkable increase in the number of cases identified following the creation of a child abuse team or unit within a hospital and the need for continuous training and active review of all incoming cases. Both programs provide a case staffing mechanism which serves a planning and coordinating function in terms of the role to be played by a variety of agencies. Children's Trauma Center is unique in that it encourages parents to attend these case staffings as a way of clarifying the expectations which the various agencies will have of them, undermining the denial of abuse, and demystifying various agency procedures.

Without specific funding for a child abuse treatment unit, it is unlikely that long-term treatment will be provided by a hospital which has many other priorities. The Oakland program demonstrates that with adequate funding a child abuse treatment unit can be developed very effectively in a hospital setting. Children's Trauma Center is an excellent example of how effective a hospital-based treatment program can be *if* the community is willing to provide the funding. In serious abuse cases the first contact with the parents is often in the hospital. This first contact can be so important in its impact on the family, while referrals to other agencies are often unsuccessful, that it seems a great waste not to capitalize on this initial relationship between family and hospital.

Children's Trauma Center of Children's Hospital Medical Center Oakland, California

By Monica Holmes, Ph.D., and Douglas Holmes, Ph.D.

Program Director: Sharrell Munce, MSW

START-UP

The origin of the Children's Trauma Center (CTC) dates from November 1971, when the director of social services of Children's Hospital Medical Center (CHMC) called a conference on child abuse and neglect. The conference was attended by representatives from public and private social service, health, education, and law enforcement agencies and other professionals in Alameda and Contra Costa Counties. Widespread interest in the conference is attributed in part to the work of the director of social services and her husband, a pediatrician at the hospital, who had stimulated interest in the problem for a period of 13 years. As a result of the conference, two task forces were developed (one for each county), as was a proposal for funding which led, in May 1972, to a grant for $20,000 from a local private foundation and one for $12,000 from the State Department of Mental Health: The CTC was born.

The CTC began activities within the hospital, with two full-time social workers and a secretary/case aide. The focus of the program was conceptualized in terms of: (1) identification, case management and treatment, (2) coordination among agencies, and (3) education of professionals. One social worker acted as treatment specialist, while the other acted as coordinator and agency specialist—a position she fills to the present day. After 4 months, a third social worker joined the staff on a volunteer basis, working half time in both direct treatment and community education; this overlapping of roles facilitated a process by which whatever was learned in identification and treatment could be taken back to the community agencies. In addition, all three social workers focused on training. Within the hospital they conducted inservice training sessions and noon conferences for interns and residents and for the 632 private physicians who use the services of the hospital. Training which covered inpatient case management issues was provided for ward nurses as was training dealing with case identification for emergency room staff. In addition, with both groups there was an emphasis on child abuse as an understandable phenomenon.

In September of 1972, the CTC Advisory Board was formed, consisting of representatives from a variety of agencies and groups, e.g., public health department, schools, department of probation, juvenile district attorney, police departments, protective services, Children's Home Society, Children's Lobby, Parent-Child Centers, Parental Stress Service, and Junior League. The Board was formed for the purposes of information sharing, discussion of new and pending child abuse legislation, planning for new services, training, and coordination. It continues to function as a viable, dynamic group.

During the first year, the two major start-up objectives were: (1) to make the program visible within the community of public and private agencies, and (2) to provide direct services which would establish the program as a genuine resource within the hospital and the community. Efforts to meet the first objective included the formation of the Advisory Board and the provision of approximately 100 seminars and presentations during an 8-month period to health, social service, law enforcement, education, and civic groups. Efforts to meet the second objective included individual and group therapy for identified abusers and the creation of a 24-hour

on-call schedule, for which the heads of CHMC's departments of social services and family guidance and the two CTC social workers each took responsibility every fourth night. In addition, each day the CTC social workers received the daily admission sheets and then reviewed any unclear or possible abuse cases with one of two pediatricians who had extensive experience with child abuse cases.

As a result of this activity, identification of cases increased markedly. Whereas in the 5-year period prior to the creation of CTC, an average of 19 cases was identified each year, during the first year of CTC operations, 78 cases of abuse (an increase of 400 percent) and 95 high-risk families were identified.

During the start-up year the hospital provided space and other in-kind services and ultimately hired a proposal writer so that CTC could increase its level of funding. CTC received $110,000 on June 1, 1973, for its second-year operating budget. With this increased funding, CTC staff grew from four to eight, including four caseworkers, a half-time pediatric resident, and an administrative specialist. The expansion made it necessary for CTC to move out of its offices within family guidance to its own small house on the hospital grounds.

CTC continued to provide identification, case management, and treatment services, and expanded its training efforts on behalf of professionals and community groups. One new aspect of the program involved training for 45 volunteers from the Junior League. Training was conducted over a 10-week period for 2½ hours per week. At the end of the training, 30 women agreed to work in the program: 10 as parent aides, 10 in the child enrichment program, and 10 in the media and speakers' bureau. In addition, training efforts were initiated on behalf of Head Start staffs and 180 Alameda County public health nurses.

Although the CTC start-up process involved a great deal of work, no major problems were encountered. Currently nearing the end of its third year of operation, the CTC can be characterized as a fully implemented program. Many of the problems often associated with start-up, e.g., jurisdictional disputes with other agencies, staff burn-out or turnover, insufficient number of referrals or requests for services were relatively minimal. Relationships with other agencies have been generally productive; the three staff members who started CTC are still there, one as the director, and the other two as training coordinators; and the program has always had an active caseload and a large number of requests for its many services.

PROGRAM OBJECTIVES

The objectives of the program are as follows:

- *Direct services*
  identification, case management, and treatment; parent aide and child enrichment programs
- *Interagency coordination*
  through the Advisory Board and through interagency staffings on individual cases
- *Community education*
  educate the public to change attitudes toward abusers and to better prepare parents through Education for Parenthood programs presented by the Junior League in the high schools
- *Training service providers*
  through training grants from Social Rehabilitation Services and the National Institute of Mental Health
- *Research and evaluation*
  measure the impact on families of CTC services through goal attainment scaling; evaluate the impact on trainees of the SRS training effort

With the exception of the research and evaluation objective, the program has, since its inception, pursued all of these objectives; they were established by the original staff and, while activities designed to meet the original objectives have been greatly expanded, the objectives themselves have not changed.

PROGRAM AUSPICE

Children's Trauma Center is administratively a part of the social service department of Children's Hospital Medical Center, which is the acute care pediatric facility for all of Northern California. It therefore has extensive facilities for providing care to severely injured children. CTC is one of three within-hospital resources for social services and psychotherapy. The social service department provides services to neglectful families whose children are cared for in many

hospital departments, e.g., nursery, wards, clinics. Family guidance serves children and families with problems in functioning, and CTC handles all abuse and high-risk cases. There is also a hospital Child Development Center which provides medical and social services for families which have children with developmental problems.

The staff of CTC is committed to the idea of a hospital-based program because the hospital is the only agency which provides 24-hour backup, in terms of both emergency room services and staff to share on-call responsibilities. CTC feels that providing a direct service, e.g., medical treatment of the injured child, is an important factor in establishing a relationship with families. Moreover, CTC defines training of doctors as a major priority and feels that this is best accomplished from within the hospital. However, CTC is housed in its own facility and, because it receives no direct funding from the hospital, is relatively autonomous in its functioning.

PROGRAM COSTS AND SOURCES OF FUNDING

The budget for 1974-75 is approximately $387,000, allocated as shown in figure 1. Sources of funding are provided in table 1.

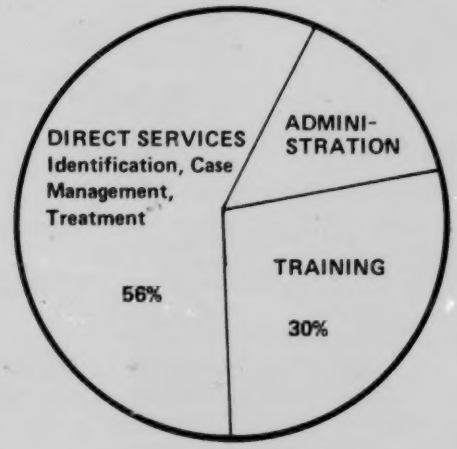


Figure 1. Budget allocation

Because approximately 65 percent of all support comes from Federal funds for specific training programs, CTC continues to seek local funding for its clinical services. The lack of assured continuity in funding makes it difficult to engage in long-range planning or to meet the service needs requested by other agencies and by the hospital. Every agency at which CRA conducted interviews expressed regret over the fact that CTC was doing so much training that it could not provide more treatment services. While CTC development of training materials and its training activities are very important, the program does fulfill a local service need which requires assured maintenance support.

Table 1. Sources of funding

	Percent of funding	
Federal		
NIMH, Manpower training	49.5	
SRS	15.9	
Total		65.4
State		
Maternal child health		5.2
County		
Revenue sharing		15.2
Private		
Zellerbach Family Fund	3.1	
Van Loben Sels	2.6	
Luke B. Hancock Fdn.	4.4	
Oakland Junior League	3.1	
Marshall Steel Sr. Fdn.	.5	
Alameda-Contra Costa	.5	
Total		14.2
		100.0

FACILITIES

The program uses two small private houses and rents space in a neighborhood church. The first house, used by the program since the start of its second year, provides space for most of the treatment staff. Basically, this house can be described as a series of offices clustered around a central living room area, which is used for groups of clients, for case conferences involving other agencies, and for staff meetings. The living room is comfortable and home-like, furnished with couches, rather than desks and chairs, thus conveying an extended family environment rather than a business-like, or clinic setting. The second house is used by the training staff, by several of the new caseworkers, and by the evaluator. The space in the church is used for the child enrichment program, staffed by the Junior League, and supervised by CTC caseworkers.

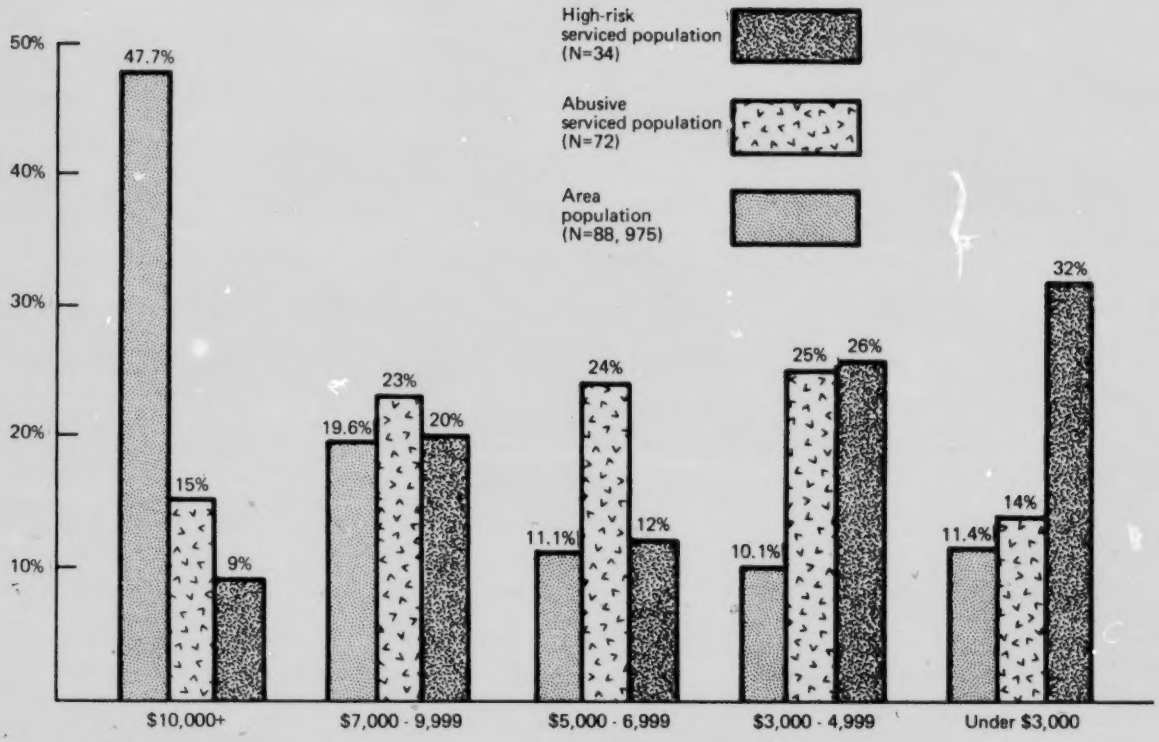


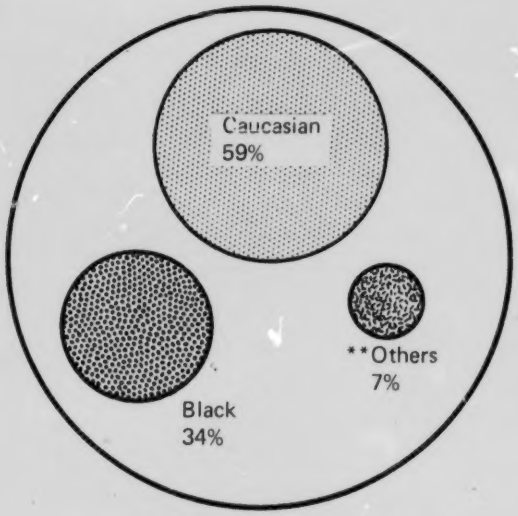
Figure 2. Income of serviced and area populations

COMMUNITY AND PARTICIPANT CHARACTERISTICS

CTC serves a 733 square mile area, with a population of 1,073,184. Since Children's Hospital Medical Center is the only acute care pediatric facility in Northern California, families come from all over this area for service. The catchment area includes a ghetto population with high unemployment and inadequate housing, as well as wealthy middle and upper-middle class communities. However, there are two additional hospitals in the county which, although they do not handle acute cases, do handle pediatric cases. Located in an area which contains a relatively high proportion of black families, CHMC serves a proportionately great number of black families, particularly in the outpatient department, from which many CTC high-risk families are drawn. The area surrounding the other two hospitals tends to be predominantly caucasian. Because the demographic characteristics of the county would be contextually misleading, in that they do not reflect the demographic characteristics of the hospital population, demographic characteristics of the City of Oakland are used. General population data and data descriptive of individuals served by the program are available in four categories: income, ethnic status, intact v. single parent family status, and age.

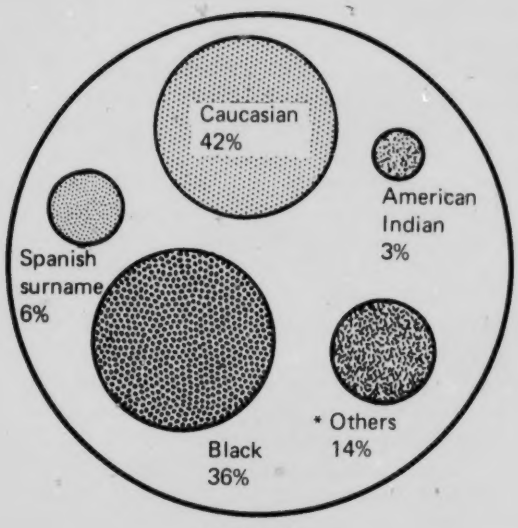
As can be seen from figure 2, high-risk and child-abusing families are overrepresented in the low-income range and underrepresented at the higher-income levels. Whereas 47.7 percent of the general population have incomes of $10,000 or more, this is true of only 15 percent of abusive and 9 percent of high-risk families. Conversely, whereas only 21.5 percent of the families in the general population have incomes of $5,000 or less, 39 percent of abusive and 58 percent of high-risk families have incomes of $5,000 or less.

As can be seen from figure 3, the catchment area population is 34 percent black; 40 percent of the abusive and 36 percent of the high-risk families are black. Caucasian families, which represent nearly 59 percent of the Oakland population, represent 41 percent of the CTC families. It seems that CTC clients are representative of the Oakland population in terms of black families, but have an overrepresentation of

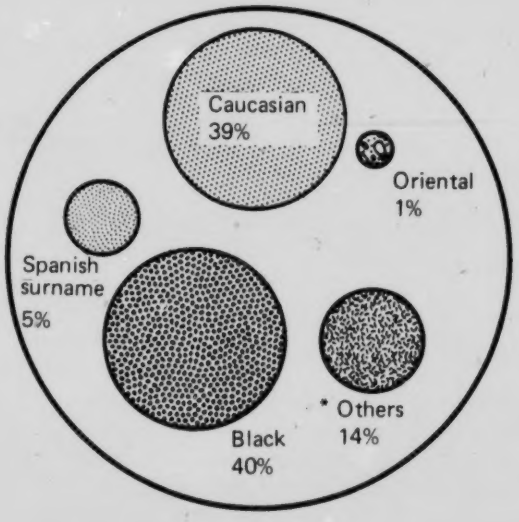


Catchment area population

** This includes all persons other than black or caucasian



High-Risk



Abusive

* "Others" refers to participants who are members of families with "mixed" marriages (i.e., Mexican/caucasian, black/caucasian, American Indian/caucasian).

Figure 3. Ethnic status

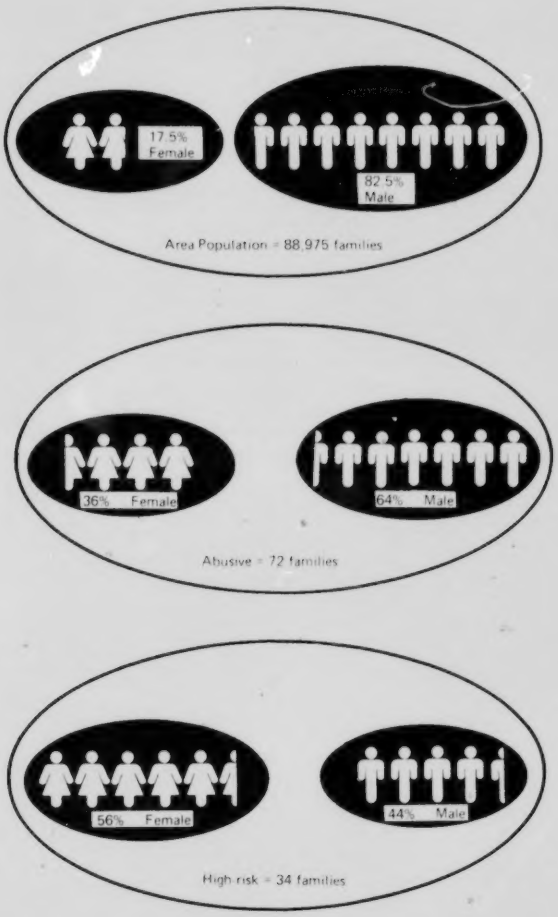


Figure 4. Head of household

families which represent "mixed" marriages, e.g., Mexican/caucasian, black/caucasian, American Indian/caucasian. Whereas such individuals represent 14 percent of CTC clients, they represent less than 7 percent of the Oakland population.

Comparisons between the Oakland population and the CTC-serviced families in terms of the proportions which are female-headed show that a very high proportion of CTC client families are female-headed. As can be seen from figure 4, whereas only 17.5 percent of Oakland families are female-headed, 36 percent of abusive and 56 percent of high-risk families are female-headed.

While the sample of high-risk families is very small, the data do indicate that high-risk families have lower incomes and are more likely to be female-headed than are the abusive families. However, these data are confounded, in that some families are being identified as high-risk at least in part because of their low-income, single parent status and the stresses associated with both of these.

As seen in figure 5, the vast majority (72 percent) of children known to the program are age 0-3 years. This is in contrast to the fact that children 0-4 years represent only 23.6 percent of the children age 0-18 years in the Oakland population. Thus, these very young children are clearly overrepresented in terms of abuse and high-risk status. The average age of abused children known to CTC is 2.2 years. It seems clear that hospital-based programs are more likely to identify a larger proportion of very young than of older children, because of the physical vulnerability of very young children.

It should be noted that in figure 5, and in subsequent figures in which age data are presented, the age intervals for the serviced and catchment area populations are not identical. This is because census data age categories were different from those in use by the reporting program. Although it may not always be possible to make equivalent comparisons between serviced and catchment area populations, nevertheless, the available data provide a picture of the extent to which the serviced population is, or is not, typical of the catchment area population.

The families served by CTC tend to be young: the average age of abusive mothers is 23.8 years and of fathers is 26.4 years (high-risk: mothers = 24.6 years; fathers = 29.5 years). In 50 percent of the cases the couple has only one child, in 28 percent of the cases there are two children, in 16 percent there are three children, and in 6 percent there are four children. Thus 78 percent of the families have either one or two children so that above average family size cannot be regarded as a factor contributing to abuse in these families.

THE STAFFING OF CTC

CTC has a full-time staff of 15, plus 2 part-time consultants. The staff is divided into four functional units; each unit has a coordinator and the coordinators of the four units meet weekly for a coordinating council. The staff structure is not hierarchal and all the staff have a considerable share in the decisionmaking process. Recognizing the exhausting and emotionally depleting quality of work with abusive

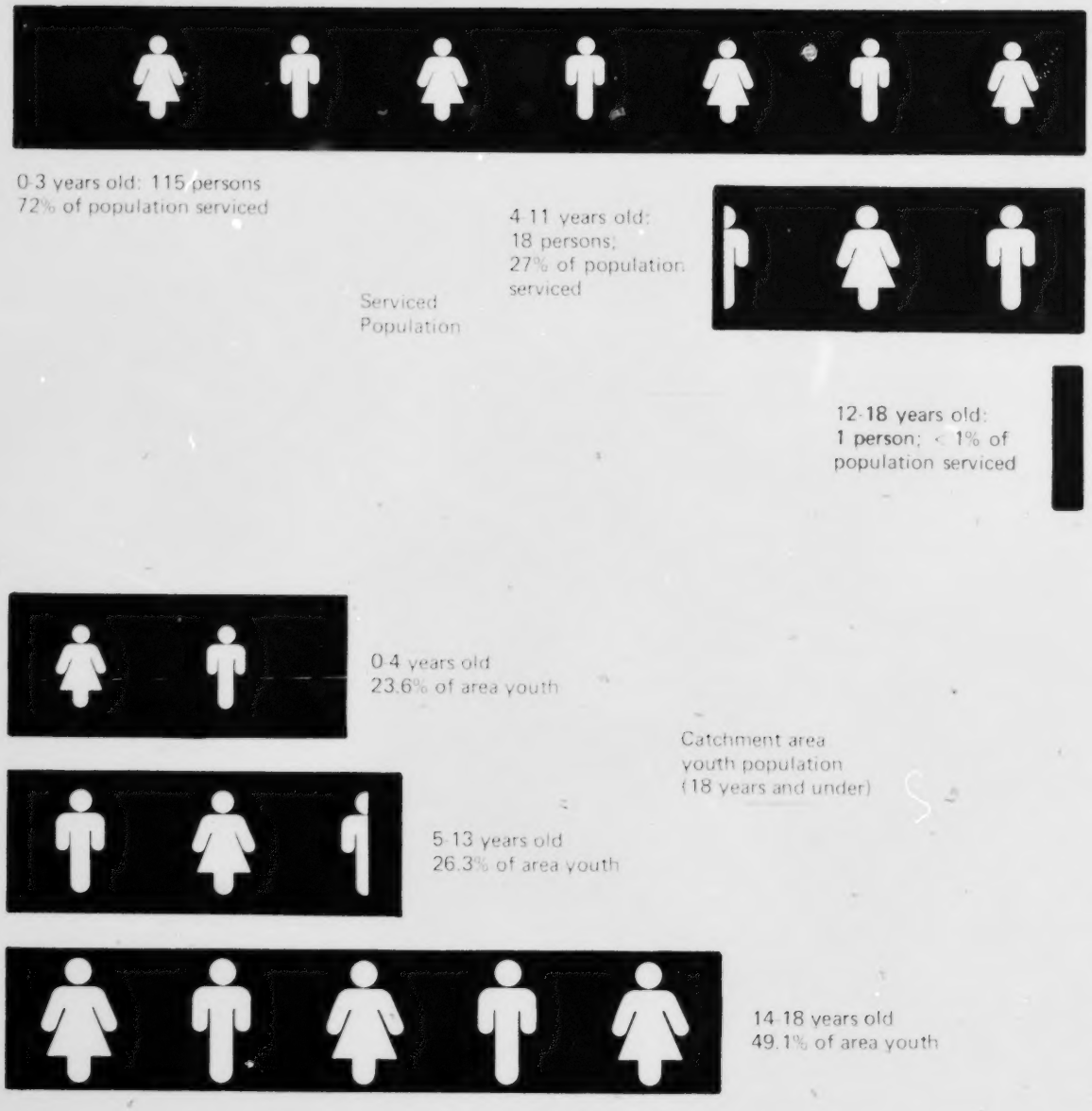


Figure 5. Number of youth in area and catchment populations

families, the staff provides a great deal of mutual support for its members.

The CTC staff organization is depicted in figure 6.

Director

The director coordinates the activities of the four unit heads: administration, training, treatment, and evaluation; meets with and works with the Advisory Board; and represents CTC with the community of agencies. The director also represents CTC within the hospital and helps to secure funding. In addition, the director is co-therapist for one of the mothers' groups.

The director, one of the three individuals who started CTC, is a social worker with an MSW.

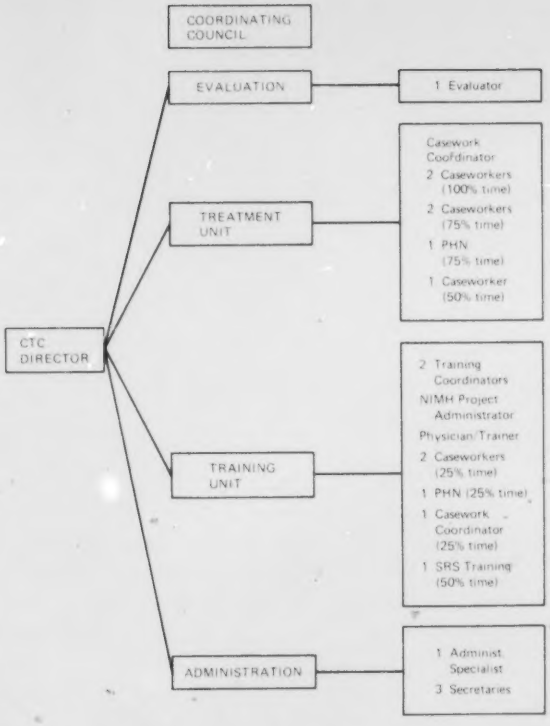


Figure 6. Staff organization

Administrative Specialist

This individual responds to and encourages requests for CTC participation in a variety of agency and public meetings and investigates resources within the community to keep abreast of developments pertaining to children and possible sources of funding. She is responsible for preparing the budget, for negotiating grants and contracts, for writing proposals for funding, and for supervising day-to-day office routine.

The individual in this position has an MSW and has been with CTC for 6 months. The individual who held this position in fiscal 1973 had responsibility for developing the funding for the current fiscal year and is currently the NIMH project administrator.

Casework Coordinator

The coordinator provides informal supervision to the casework staff on an individual basis and formal supervision for the unit during the weekly 2-hour treatment unit meeting. In addition, she carries several individual treatment cases, is co-therapist of the couples' groups, and 25 percent of her time is addressed to training. She coordinates services between CTC and community agencies, as well as acting as a consultant to these agencies.

The coordinator has only just accepted this position, having served as acting coordinator for several months. She has an MSW and has been with the program for 14 months.

Caseworkers and Public Health Nurse

The five caseworkers and one PHN have responsibility for intake, for case management, and for treatment. In addition, three of the caseworkers and the PHN have training responsibilities for one quarter of their time.

Caseloads vary both in size and composition from one worker with no couples to another with eight couples in couple therapy (average number of couples per worker = 2); and from a worker with 3 individuals in treatment every other week to a worker with 12 individual cases seen weekly (average number of individuals in individual therapy per worker = 6). In addition, caseworkers have up to 15 cases which are not in active treatment but for which they have case management responsibilities. These cases are followed approximately once a month to once every 3 months, either through contact with the family or other agencies.

Two of the caseworkers have a specialized caseload in that it includes children, three of the caseworkers do group therapy in addition to their other responsibilities.

Three of the caseworkers have an MSW, one has an MA in clinical psychology, and one an MA in counseling psychology; the PHN has an MPH in public health. Two of the staff have been with CTC for 2½ and 1½ years respectively, the other three have been there for from 7 weeks to 4 months; the PHN has also been there for 7 weeks.

In experience, they range from two individuals for whom CTC is a first postgraduate degree job to the rest of the casework unit staff, which has from 4 to 8 years of experience in social service work, in foster care, probation and welfare, and public health.

Training Coordinator—NIMH

The responsibilities of this individual include coordinating the total NIMH training program, conceptualizing and writing the mental health and social welfare/public health nursing training modules, and planning and conducting training

sessions. In addition, she is co-therapist of one of the mothers' groups, carries a small caseload, and represents the training unit on the coordinating council.

She has an MSW and 2 years' postgraduate experience as a supervision worker, as well as earlier experience in community organization.

NIMH Project Administrator

This individual co-authored the Prevention module and has training responsibilities. In addition, he has responsibility for making all of the administrative arrangements concerning the NIMH training grant. He acts as liaison between CTC and the public agencies in the counties in which CTC is conducting training and between CTC and the firm conducting the evaluation of the training. He schedules all training sessions and makes arrangements for necessary equipment.

Training Coordinator–Social Rehabilitation Services

This individual, with the help of other trainers on the staff, planned the 10 statewide 2-day training sessions for all welfare agencies throughout California, as well as 15 followup sessions. This training was the model which was greatly expanded for the NIMH project.

In addition to planning and conducting these trainings, she works 25 percent as a caseworker, supervises the parent aide volunteer program, and has helped to plan the NIMH training.

She has an MSW, a year's experience as a juvenile court child dependency worker, as well as prior experience in foster care and community mental health.

Consultants

The two training consultants, one of whom is a physician, have responsibility for writing the training modules and for conducting some of the training. The physician-trainer is a board-eligible pediatrician who had previously spent 9 months working with CTC. He is responsible for writing the health training module and for conducting training for health practitioners.

Evaluator

The evaluator has responsibility for compiling client profile data, for developing a strategy for measuring impact of treatment on clients, and for evaluating the effectiveness of the training conducted under the SRS grant. She has been with the program for 9 months, having worked in research in socio/medical settings for 6 years. She has an MS in psychological counseling.

DIRECT SERVICES: PRIMARY AND SUPPORTIVE SERVICES

Primary Services

The following services are available:

- Identification
- Case management
- Treatment: adult individual, marital counseling, conjoint couple group, mothers' group, individual child
- Supportive services: 24-hour crisis on-call, parent aides, child enrichment sessions, trauma clinic, emergency fund

Each of these is discussed in turn in terms of process and the techniques used.

IDENTIFICATION

Some cases coming into the hospital are identified by the house staff or by the family pediatrician, other cases are identified by CTC through its program of active outreach into the hospital. The CTC case aide checks the daily admission sheets every weekday and reads the charts of all cases associated with any injury which could be the result of abuse, e.g., all fractures, head injuries, seizures, burns, ingestions, failure-to-thrive. Each case is discussed with the nurses and with the physician in order to establish whether or not there is any possibility of abuse. For example, any of the following are viewed as "indicators" of abuse: if the medical findings are inconsistent with the parents' explanation of the events surrounding the injury; if the parent is reported to have inappropriate expectations or perceptions of the child; if the child is watchful, frightened, withdrawn, or combative. If abuse is suspected, an interview with the parents is requested. Wherever possible, the child's physician participates in this initial diagnostic interview with the parents.

Usually the interview with the parent(s) takes place the same day as admission (or the day following a night admission if CTC was not called in immediately) and is conducted by one

of the CTC caseworkers, each of whom is responsible for intake 1 day a week. The initial interview takes place either at CTC or on the ward when the parents come to visit the child. The purpose of the intake interview is twofold: (1) to assess the parents' potential for abuse and to decide whether the injury should be reported as abuse, (2) to provide support to the parents and to establish a positive therapeutic relationship. In terms of the first goal, the focus of the interview is on the parents' own background and history of abuse or severe criticism and availability of a supportive network, the parents' perceptions of the child as different or as excessively demanding, and the existence of a crisis either in the couple's relationship or in the life circumstances of the family. In terms of the second goal, the focus is on letting the parents know that they are not horrible people, that other people with their difficulties have been helped, and that the important thing is for everyone to work together in order to prevent the reinjury of the child. It is felt that reaching out to parents precisely in the midst of the crisis is often an important factor in establishing a therapeutic alliance.

In the majority of cases, as the interview progresses, the intake worker can determine whether or not the case will be reported and is able to inform the parents accordingly. Where warranted, the worker lets the parents know that there is still no decision and brings the case for discussion with other CTC staff. Following such discussion, the parents are informed of the decision. The intake worker makes it very clear from the beginning of the contact that there will be no confidentiality surrounding the injury, that the story which the parents are telling is not plausible in light of the medical findings, and that she/he will do everything to provide the parents with information and support. Often the intake worker is present for the interviews with police and with probation.

The mandated agencies to which the report is made are the police and the department of probation. While CTC staff is very clear about the need to report suspected cases, they do discuss constraints to reporting to the police, which center primarily around the fact that some cases are prosecuted in criminal court and that this is not seen as helpful to the family. When such prosecution occurs, CTC is often instrumental in helping the family obtain legal assistance.

Once the report has been made, the identification phase is over. CTC has only just begun to collect data on the number of CTC intake interviews which result in a no abuse/no report determination. It is known, however, that of the 53 abuse cases reported by CTC to the authorities in 1973, 51 were judged valid by the authorities.

High-risk families are those in which all of the characteristics of abusive families are present, but in which there has not yet been any overt abuse. These include failure-to-thrive cases, emotional abuse, and accidents caused by neglect or failure to protect. When the dynamics of abuse are present, i.e., the parents have a history of abuse or severe criticism in their own background, the parents lack a supportive network, the parents view the child as "different" or as excessively demanding, and the life situation of the family includes considerable stress or a crisis, the family is considered to be high-risk, even without specific injury which can be clearly attributed to the parents. In other words, injury may be unclear in terms of its status as intentional v. accidental, the parent may be unduly anxious and may be bringing an uninjured child to the hospital as a way of calling attention to abusive impulses, or a child may be uninjured but thriving poorly.

CASE MANAGEMENT

The task of case management is to ensure coordination among the agencies involved in any given case. Interagency case conferences are called for the purposes of staffing new cases, for restaffing prior to court appearances, and often for restaffing prior to the reentry of a child into the home. Case conferences hosted by CTC generally include the CTC case manager, a representative from the police, the probation officer, a public health nurse, the protective services worker, and, in approximately half the cases, the parents themselves. If they are willing, parents are always included, with a few fragile exceptions.

The initial case conference is designed to prepare the family and to achieve integration of the service delivery network around an individual case. The case conference clarifies for the parents expectations that the various agencies have of them, lets them know of areas in which they must change, cuts through the parents' denial of the abuse through frank discussion of

the occurrence, demystifies various agency procedures, and allows agencies to exchange information and to discuss recommendations to the probation department regarding recommendations it will make to juvenile court regarding the disposition of the child.

In addition, the case conference serves a decision-making function delineating the role of each agency in the particular case and the treatment of services best suited to the family's needs. Finally, the case conference serves to prepare both the family and the professionals for whatever court appearances become necessary.

Case management remains an essential aspect of virtually all cases throughout the treatment phase. Clients' children who are in placement are followed, in collaboration with placement workers. CTC works to ensure a cooperative relationship between biological and foster parents, participates in foster care visits, and, in the case of children returning to their homes, advocates for a gradual transition.

TREATMENT

CTC offers individual therapy for parents and children; maintains two mothers' groups, the membership of which ranges from six to eight women each; one couples' group which currently has two couples but which has included as many as four couples; and marriage counseling for individual couples. Some individuals participate in several modalities.

The determination of treatment modality is chiefly up to the individual caseworker in conjunction with the client(s). While group therapy is considered to be the treatment of choice, it should be noted that there are no more than 16 individuals actively enrolled in group therapy. In CTC's experience, most parents need to be seen individually before they are ready to move into a group. Some individuals characterized as too explosive or as so intensely needy that they cannot wait their turn and require the therapist's full attention, or as too fragile in terms of their level of integration, never move into a group. Others who are involved in a marriage or other stable relationship are seen as a couple; some couples also participate in individual therapy for one or both partners, but couple therapy and group therapy as a combination seem to be less common.

Most clients in active treatment are seen once a week, although in times of crisis contact may be daily and extensive. Clients who participate in more than one treatment modality are seen more than once a week, the number of times a week corresponding to the number of treatment modalities in which they participate. Home visits are more likely to occur early in the case management phase and during times of crisis; most therapy sessions take place at CTC.

Criteria for improvement in therapy include the following: acknowledgment of the abuse or of the possibility of abuse, i.e., a diminution of denial; ability to recognize feelings, especially anger and fear so as not to act out these feelings, i.e., awareness of the danger signals; ability to see others as helpful, i.e., increase in the level of trust and decrease in the level of isolation; ability to see child(ren) differently, to recognize the child as a separate individual with legitimate needs rather than as a demanding, manipulative, or assaultive force; ability to recognize self as a likable and worthwhile person, i.e., an increase in self-esteem; improvement in communication and the ability to provide mutual support in the case of a couple; and stabilization of situational crises.

The CTC feels that they have not been providing services long enough to have discharged many clients as "cured." Cases are described in which there has been marked improvement, but even in these cases there tends to be continued contact and followup. In such cases, contact seems to range from once a month to once every 3 months, just to see how the individual or family is coping. As in all treatment programs, there are a few families which disappear, particularly high-risk families for which the court has not mandated treatment. Most families appear to remain in active treatment for 1 to 2 years.

Before discussing each treatment modality and some illustrative case examples, it is important to describe the CTC view of the causes of child abuse and its treatment philosophy. This philosophy was initially formulated by the core group of three social workers, but has been integrated by the rest of the staff.

Child abuse is conceptualized as an outcome of the negative interaction between intrapsychic and societal forces. In terms of societal forces, in addition to poverty and environmental stress, CTC staff uses social context as an explanatory construct. In this view, our competitive society in which people tend to be critical rather than

supportive, in which violence is a way of life, in which a request for help or the expression of feelings is interpreted as weakness, in which hierarchical scapegoating results in the greatest amount of hostility being directed to society's weakest members (e.g., minorities, children), and in which parents are expected to cope with childrearing with little training or support, is seen as one major causative factor. Intra-psychic causes are described in terms of the major defenses of abusive parents: denial, projection, displacement, and reaction formation. Abusers are characterized as individuals with a very high level of investment in their children, for whom they also have very high performance expectations; high performance standards for themselves in terms of cleanliness, parenting, and household management; low self-esteem as a result of the internalization of parental criticisms; intense unsatisfied dependency needs with a lifelong need to defend against these needs through interpersonal isolation; and intense hostile-symbiotic attachment to their families of origin from which there has never been adequate separation. For some parents the threat of separation posed by toddlers is intolerable to their symbiotic need for closeness, for others the intense dependency needs or the messiness or the imperfections of the infant are intolerable.

Thus, the CTC view of the child abuser is essentially of an intensely self-critical dependent individual with low self-esteem who is unable to recognize his dependency needs and who tolerates no gratification from self or others. The most important CTC treatment concepts center around "reparenting" and "validation." Since abusive parents are seen as individuals who experienced only abuse and/or criticism at the hands of their own parents, treatment is conceptualized as a reparenting process. The aim of reparenting is to put the parent in a warm, accepting, and supportive relationship. Such a relationship includes education, limit setting, and concrete help and assistance. Reparenting is not conceived as a return to childhood and regression is not encouraged. Rather, CTC staff seeks to appeal to and strengthen the more mature adult aspects of the individual.

A primary way of providing a nurturing reparenting experience is through validation. Validation is used in individual, couple, and group sessions as a technique to get these self-critical individuals to hear something positive about themselves. For instance, group sessions begin with a "news and goods" period in which every group member, including the therapist, has to say something positive that they experienced in the past week. In another exercise called the validation sharing circle, which ends each group session, each person is expected to say something positive about her neighbor who is not allowed to invalidate the statement with a "yes but" comment. From the first intake interview, the effort is to validate what is positive about each parent, e.g., emphasizing the fact that the child is abused but well nourished and cared for, or that the parents brought the child to the hospital immediately.

Another technique CTC uses is called "talking to the wall." In this technique the therapist informs the client that his/her feelings behind his/her actions are quite understandable and are shared by many others or elucidates what most people in a particular situation would feel. This technique is designed to minimize self-criticism which is often maximized by interpretive statements, to make abusive parents feel that they are part of the human race, and to make them aware of and able to experience their feelings of fear and anger. Other techniques are used to help people deal with and experience their feelings. When a person is stuck in a feeling, she/he is helped to exaggerate the feeling or to contradict it. Thus, a person who feels put upon by others and is complaining a great deal may be asked to talk about the fact that everything and everyone is so dreadful to the point of parody and ultimately laughter, or the person may be asked to pretend that everything is simply marvelous. In any event, these techniques encourage clients to get past certain feeling states which include complaining, feelings of hopelessness, and dissatisfaction.

As part of reparenting, CTC staff initially appeals to the yearning for dependency and supports the development of a dependent relationship. A sequential development of real, rather than pseudo, independence then begins. At the beginning of treatment, dependency is encouraged and things are done *for* the client; gradually the therapist is doing things *with* the client, and finally the client is encouraged to do things *on* his/her own.

Therapists share some of their experiences, feelings, and reactions freely with their clients. Group members are encouraged to socialize with each other and to provide each other with a supportive peer network. The three groups have

co-therapists to reduce the drain on any one worker, but also to model a positive peer-sharing relationship. Some couples, if they are especially demanding, also have co-therapists.

It should be clear that the CTC treatment model differs greatly from a traditional model in which patient-therapist confidentiality, therapist detachment, and patient motivation figure prominently. CTC therapy is not necessarily confined to an office, is not limited to a 55-minute hour, and may involve response to a client's need at any hour of the day or night.

The cases which follow the description of treatment modalities are intended to illustrate the CTC treatment philosophy and techniques.

Individual Therapy

Individual therapy is not the treatment of choice for those who can participate in a group or in couple therapy. Individuals who are not part of a psychological couple, or whose spouse refuses to be involved in treatment are at least conceptually assigned to group therapy. However, some individuals cannot participate in a group setting, either at the beginning or over the whole course of the treatment and therefore individual therapy is the only alternative. Particularly during the early case management phase where there are a great many reality problems which have to be sorted out, individual rather than group therapy seems to be the treatment of choice. The case of Jackie illustrates this use of individual therapy.

Jackie

Jackie's 2-month-old infant son, Nick, was referred by an intern in the emergency room as a possible abuse case. He had a fractured humerus and his injury did not match with Jackie's report that he had fallen out of bed. Nick and his twin sister, Nancy, were full-term babies who were premature in terms of their weight. Since Nick weighed only 2 pounds at birth, he remained in the hospital for 1 month which may have contributed to the fact that an initial bonding between him and Jackie did not take place. When he was sent home he was colicky, a poor eater, and very difficult to care for. The need to simultaneously care for Nancy did not make Jackie's job any easier. In addition, there were other stress factors operating. When Jackie was 7 months pregnant she went through separation with her husband, who was drinking heavily. She became so depressed that she was hospitalized for the last 2 months of her pregnancy. During this same time period the husband's father, with whom she was particularly close, died leaving her without her closest friend and source of support.

Abused by her own stepfather as a child, she was highly self-critical and depressed when first seen.

Currently, Nick is in foster care and Nancy is living at home. The focus of the therapy sessions is on Jackie's anger and on education about child care, growth, and development. Thus, there is a strong educational component in the sessions with this client. In addition, the case management aspects of the case are very demanding: Nick and his foster mother are seen regularly because he is a very difficult baby to manage, Jackie's mother and her three sisters have been seen in order to help them develop a support system for Jackie and in order to help the mother prepare for the time when she will begin to care for and raise Nick. In addition, Jackie is being seen by a consulting psychiatrist in order to evaluate the level and depth of her depression; CTC is helping her pay for a lawyer out of its emergency funds because she has been charged in criminal court and Nancy is being seen in the special weekly trauma clinic so that her continued development and progress can be carefully monitored.

This case is illustrative of the early phase of treatment which, for a single adult, is most likely to be individual therapy, with a major emphasis on providing supportive services, on therapist availability, and on assistance in dealing with feelings.

Couple Therapy

Couple therapy is described as the treatment of choice when there is an actual or psychological couple and the interaction between them is a critical factor leading to the abuse and the creation of an indequate home environment. The case of Bill and Betty illustrates the process of couple therapy.

Bill and Betty

This couple was self-referred to CTC following their move from another city to Oakland. Prior to their move, Bill had turned a burning hot shower on their 4-year-old daughter resulting in second- and third-degree burns on the

major portion of her body. At the time of the abuse, the family was in the process of being evicted from their house and Bill's job was in question. In fact, on that same day he had been severely criticized by his employer. The child was an exceptionally bright little girl who tended to be very negativistic and testing of parental authority. Immediately prior to the incident, she had soiled herself and had refused to get undressed when requested to do so by her father who wanted to wash her off. Her refusal triggered his putting her into the burning shower.

Not only did the couple have to cope with a great deal of stress and a provocative child, but also the maternal grandmother is described as being exceptionally destructive and interfering.

The goal of therapy was to help them look at their high expectations of themselves and their interactions with each other as well as with their daughter. Bill tended to be extremely inhibited and constricted and was unable to talk about or experience his feelings at all. Treatment centered around helping them see the ways in which they affect each other and their need for mutual support. In addition, the therapist estimates that approximately one-third of the therapeutic interactions with this family are centered on teaching Bill and Betty how to cope adaptively with their daughter in terms of child management. Techniques of behavior modification and open discussion of feelings between parents and child have been initiated and are reported to have improved relations between them.

Case management or service coordination aspects of this case are illustrative of CTC work with families. The family was referred to fair housing so the appropriate housing could be found; coordination with probation, juvenile court, and criminal court was extensive. CTC worked closely with the lawyer and participated in all juvenile and criminal court hearings. The final outcome of the court proceedings was that Bill is on 3 years' probation and the jail sentence is waived as long as he continues in treatment. Thus, like many CTC cases, this is a long-term case which involves not only ongoing psychotherapy but also case management aspects as the case is reviewed by the court every 6 months.

Sandy and Dan

This couple illustrates the complexity and pathology of many of the CTC cases.

This couple has been in treatment for 8 months and was referred 2 months after 1-year-old Patricia had been removed from the home.

Sandy is from an overprotective, critical family and is characterized by extreme passivity. She had just given birth to Patricia when she met Dan. Dan had been married once before and had also had a child, although he practically never saw this child. He had been raised by his mother and a stepfather who was never, until adulthood, identified as a stepfather. Both of these individuals were alcoholics and Dan was severely exploited and repeatedly physically abused. His mother had enormously high expectations, never praised him, and engaged in extremely sadistic acts with him.

When he met Sandy, he used heroin but was not addicted. Discharged from the army as a chronic paranoid schizophrenic, he had never been able to work and continues to be unemployed. Recreating each of their earlier situations, Dan is hypercritical of everything Sandy does and was particularly critical of how she was with her baby. While feeling that he had to take responsibility for the care of the baby, he began to have abusive feelings toward Patricia and once put his hand over her mouth until she actually stopped breathing. He described this incident to his wife and the public health nurse who reported him to protective services. Eventually, the police and probation became involved, as well as a lay therapist from the Parental Stress Service.

In addition to the case management aspects of the case which require ongoing coordination of services as Patricia is still in a foster home and Dan has had a fairly recent psychiatric hospitalization, therapy centered around Sandy and Dan's relationship with each other. In therapy, treatment has focused on the couple's expectations of one another, on what Patricia means to them and to their relationship, and on trying to recapture the feelings associated with Dan's horrendous childhood experiences. While the therapist has openly wept over some of these incidents, Dan has, to date, felt nothing.

Since the decision as to whether or not Patricia can be returned home is pending and since the couple has a newborn baby, therapy focuses not only on an attempt to reconnect past experiences with well-isolated feelings but also on the present. Patricia comes home on visits but Dan has obsessive thoughts that he will hurt her and is thus far denying any concerns

about the new baby. At present, therapy is focused on helping him recognize and deal with his anxiety about the new baby. Patricia may eventually be placed with Sandy's mother which is not a solution to anyone's liking since she is described as a destructive and hypercritical woman.

Group Therapy

Both of the mothers' groups have been in existence for well over 2 years and the cases described are relatively long-term group members. The first two women described, Betsy and Margaret, are from one group and Karen is from the other.

Betsy

Betsy has been part of the group for approximately 1½ years. In addition, she and her husband are seen by two other CTC therapists in couple therapy and one of these is also treating one of her children.

A woman in her midtwenties, Betsy is characterized as being intensely needy emotionally. Initially she was referred by Parental Stress Service following repeated calls and lengthy conversations in which she let it be known that she was being physically tougher with her children than she intended. The youngest child had been referred to probation by another hospital because of a skull fracture and there was some question as to whether there was or was not any abuse.

Initially, because she was so exceptionally demanding, Betsy was seen in the group and in individual therapy. After 4-6 weeks in individual therapy she began to describe past injuries she had inflicted on the children and their seriousness. In a weekend phone call, she revealed that she had in the past and had just then given her 1½-year-old child valium pills because they served to make him more manageable. She was told by her therapist that this incident would have to be reported to the authorities because she was giving a clear message that she could not deal with the normal behavior of this child. When the probation supervision worker who had been involved with the family at the time of the skull fracture, but who had not continued to work with them actively, came to investigate, Betsy told him everything she had been doing with her children. She described marked feelings of revulsion toward her eldest child, a girl of seven who was born to Betsy and her first husband at the age of 18. By her present marriage she had two children, a girl age 3 and a boy age 1½. Thus, while the "identified" or disliked child was the eldest, the younger two were the ones who were abused. In other words, the revulsion experienced toward the eldest was defended against through displacement of hostility onto the younger children.

At this point, the children were placed in emergency foster placement and a coordinating case conference was held between CTC, probation, protective services, and the parents. This conference represented the father's first visit to CTC. During the conference, it was recommended that the children remain in foster placement temporarily, which Tony, the father, did not at all like. He was insistent that the children come home in a month, but Betsy was able to say that she really did not feel able to care for them. It was pointed out that there were areas of tension between the two of them and couple therapy was suggested. While Tony was not at all pleased with this arrangement, he did agree, and at that point another therapist was assigned to assist Betsy's individual therapist in working with the two of them as a couple.

In couple therapy the emphasis was on Betsy's and Tony's need to learn to communicate their needs to each other. They were asked to reflect on and let the other partner know what their needs were and what it meant to each of them when the other acted or reacted in a particular way. Ultimately, the co-therapists began to work on the fact that Betsy would whine and demand beyond anyone's reasonable tolerance limits and Tony was unable to give at all. The therapists began to discuss with the couple their own reactions to their interaction and Betsy and Tony began to see some of the destructive aspects of their interaction.

In the group, Betsy started out by acting in a very superior manner to the other group members. She was the best off member economically as well as the best educated and she used these advantages as weapons against the others and as a defense against her initial fear of the group. When the group co-therapists discussed with her their reactions to the way she was acting, she began to act as a helpful, involved group member. Her discussion of her revulsion toward her eldest daughter was particularly helpful in that it opened up the feelings of the other mothers. They, in turn, were helpful in working with

Betsy to understand the impact of her feelings on the little girl. One of the other mothers talked about her experiences as a foster child and helped Betsy to focus on the ways her daughter was feeling and on the kind of things that she must be thinking about and questioning. Whereas prior to Betsy's entry into the group, more of the group discussion focused on sharing of experiences with men, following her entry and her discussions about her feelings toward her daughter, the discussion began to focus more on parent-child experiences.

Since the group did spend considerable time complaining about their men, and since these complaints seemed to be counter-productive in terms of helping them to see their own role in their difficulties, or in terms of motivating them to take action of some sort, the therapists put a limit on the amount of complaining about mates which could be done in the group. The message was that either they would have to find a way to deal with their mate or leave him, but that they could not stay in a relationship and endlessly complain. Betsy stimulated this treatment philosophy as she took up a great deal of the group's time whining and complaining about Tony and presenting her viewpoint that everything would be all right if only he would change.

The therapists began to discuss with Betsy their negative reactions to her demandingness and the self-defeating way in which she made such enormous demands on people that she forced them to reject her. The group then began to talk about their needs for gratification, the fact that total gratification is impossible to obtain, and that it was better to have some gratification than to push people away by demanding too much. Discussions about gratification needs led to talk about their own mothers and the negative feelings they had toward them. Prior to this phase, many group members had not expressed negative feelings toward their own parents. At this time, there was a lot of sadness and crying in the group as the members began to deal with their growing awareness that their own parents would never be able to fulfill their needs.

After slightly more than a year in therapy, the children were returned to Betsy and Tony. Betsy is far less demanding and no longer feels constantly deprived. She has still not resolved her feelings of revulsion toward her eldest child, who may eventually have to be permanently placed. As Betsy begins to work more on her hostile-symbiotic relationship with her own mother, who lives only three blocks away, she may work through and resolve her feelings toward her daughter who everyone agrees is an unusually attractive and charming child.

Margaret

Margaret has two children ages 4 and 3. The family was referred from the emergency room and the mother said it was the father who had injured the child. However, 2 years later, it is still not clear who was directly responsible for the injury.

Because of her isolation and because her husband was of such limited intelligence and passivity that couple therapy was ruled out, Margaret was placed in the mothers' group.

Margaret was raised in foster homes and in a juvenile shelter. At age 20 she took LSD and jumped out of a window, breaking her back which resulted in a permanent limp. Intermittently, she had been a prostitute and used heroin.

With the help of the group, Margaret was able to realize that her husband was a totally unsuitable mate and she was able to separate from him. CTC got her into a residential program for single mothers and she continued in the group. The residential program helped her a great deal with parenting and child development issues.

However, when she left the residential treatment center she developed a relationship with a pimp and went back to heroin. At this point, CTC made a report to probation, which in turn filed in juvenile court to have the children removed and had Margaret admitted to a drug treatment program. CTC staff told her that all CTC services were available to her, but that she could not come to the group. Coming to the group was so important to her that it was felt that this limit setting might motivate her to make some positive changes. Instead of group sessions, she was home visited by the group's therapists who did a great deal of confronting her on her behavior.

Following this intervention, Margaret terminated her relationship with the pimp. A coordinating conference was held and a 6-months contract was written with Margaret in which it was specified that she would have to do four things in order to get her children back: (1) visit the foster home every week for 2 hours, (2) have

hip and ankle surgery which was long overdue, (3) find adequate housing with a backyard, and (4) get a urinalysis 2 times per week. She has met all of these conditions and it is hoped that following the upcoming court hearing her children will be returned.

Karen

Karen comes from a family in which her parents separated when she was very young and she was raised by her mother who worked in a factory and was extremely poor. At the age of 12 she went to live with her father, who was economically better off but who ignored her and was unable to meet her emotional needs.

She was married at a very young age to a man who repeatedly beat her very badly. She ran away from him many times and each time he would find her, beat her up, and they would have a brief reconciliation. She had three children by him.

He was in the process of beating Karen when their 4-year-old son, Lenny, tried to stop him. The father threw the child against the wall and when the police came they beat the father up in front of the child. Following this incident, Karen's sister sent her money to come to the West Coast so that she was finally able to leave her husband. Once on her own, she became alarmed over how rough she was with her children and joined a group at another organization. Lenny, who was very disturbed, was being seen by family guidance at CHMC. Eventually, because she did not feel she was being adequately helped in her other group, Karen was referred to CTC.

In the group she expressed her tremendous feelings of guilt and self-blame. With an emphasis on co-counseling and validation, the group kept pointing out her strengths and ways in which she had struggled to make things better. Similarly, the group worked with her on her feelings about her childhood and helped her to see that everything that happened to her was not her mother's fault. She was helped to see that her mother was unable to do any better; as she has begun to understand this, she has grown in her ability to see her son as a separate person with legitimate needs.

Through the group co-counseling and validation efforts, she has moved from a position of being reluctant to say anything and introducing most statements with "this isn't very important" to a feeling of self-worth and self-respect. When she first entered the group, she could find nothing positive to say for the "news and goods" time, but now she is described as having lots of things to say and usually says, "Can I tell one more thing."

When she first started treatment, she was unable to separate from her 2- and 4-year-old children and felt that she had to be constantly with them. Currently she brings them to the child enrichment group 2 days a week and uses that time for her art work. Formerly she never allowed herself any time to herself.

Lenny is currently reported to be doing much better although he has a teacher who is not sensitive to his needs. Karen brought this problem to the group and used the group to help her role play what she could say to the teacher to get her to be more helpful.

Child Therapy

Two of the casework staff do some work with children. Most of the children known to CTC are too young for any psychotherapy. However, a few families have older siblings and in some cases the abused child is old enough to participate in a therapeutic relationship. The following case is intended to illustrate both the complexity of problems encountered and the kind of intervention used.

Terry

Terry is a 12-year-old girl who has been living with her grandmother since the age of 6 months. Terry's mother is 25 years old and has seven children, of whom Terry is the oldest. Terry's mother is a psychotic woman with a history of hospitalizations, who works as a prostitute on the same corner as Terry's school. As Terry comes out of school, her mother calls out, "Don't forget I'm your mother," so that all the children in school know about her mother and shun her. Each week her mother brings a different man to the house and introduces him to Terry as her father.

Terry's grandmother is convinced that Terry is going to be a prostitute just like her mother and therefore allows her no autonomy. Rebelling against the rigid controls which prevent her from participating in any after-school or weekend activities outside the house, Terry has twice run away from home. This has only served to confirm the grandmother's suspicions;

she regularly calls the police if Terry is 5 minutes late from school or the store. Terry sleeps in a single bed with her grandmother because the grandmother is afraid that Terry could slip away from a larger bed without the grandmother noticing.

The therapist provides a great deal of support to Terry, reinforces her many assets, and tries to discuss with her ways in which she can convey a sense of responsibility and competence to her grandmother. Efforts have also been made to work with the grandmother and with the grandmother and Terry jointly to help them to come to some accommodation and to modify the grandmother's restrictions.

Supportive Services

TWENTY-FOUR HOUR CRISIS ON-CALL

CTC, family guidance, and social services staff participate in a 24-hour on-call schedule. Each staff member is on call approximately twice a month. While compensatory time for this service is a goal, it is reported that the demands of the program rarely permit it. Families in treatment are encouraged to call if there is a crisis, if tensions arise, or if they feel unable to cope. This service is also available to community professionals who may need consultation.

PARENT AIDE PROGRAM

CTC has 10 parent aides, 6 of whom have worked in the program for 2 years. As mentioned in the discussion of CTC start-up, the 10 parent aides are all members of the Junior League. They received the 10-week training given to all of the Junior League participants and currently meet with one of the treatment staff on a weekly or biweekly basis. Each parent aide is assigned one family with which she works. The parent aide is conceptualized as a special friend with whom to talk, have lunch, go shopping, keep doctors appointments, etc. Aides usually spend approximately 2 hours a week with the mother with whom they work, but some spend up to 4 or 5 hours. Parent aides are encouraged to relate to their own experiences and to give childrearing or personal advice, if solicited, based on these experiences.

The parent aides are usually assigned to women who are very isolated, as a way of breaking through the isolation, and who express an interest in forming this kind of relationship, once CTC makes known the availability of parent aides.

CHILD ENRICHMENT PROGRAM

The child enrichment program currently serves approximately 15 children age 2 months to 5 years. The program operates in a church basement on Tuesdays and Fridays for 3 hours each day. The program is staffed by the Junior League under the supervision of two CTC caseworkers. The Junior League workers meet with their CTC supervisors twice a month in order to discuss the program and its children. The objective of this program element is to provide the children with an enriched, stimulating environment.

Currently, CTC and the Junior League are working to set up a crisis nursery for 4 hours a day, 4 days a week. They expect to hire a half-time professional with a degree in child development to staff and supervise the program.

TRAUMA CLINIC

CTC pays a hospital pediatrician to operate a special 3-hour clinic for abusive and high-risk families one morning a week at the hospital. The weekly clinic gives the pediatrician the opportunity to follow the progress and development of the children very closely. In addition, this particular pediatrician is well versed in child development and understands the emotional needs of abusive adults. Thus, considerable time is spent discussing developmental milestones and childrearing techniques in a very practical and supportive manner.

EMERGENCY FUND

CTC maintains an emergency fund for use by its clients. Any caseworker can give a client up to $10 at his/her discretion. Amounts larger than $10 have to be discussed with and approved by at least four other treatment staff members. In the case of larger amounts of money, the expectation is that those clients who can, will pay back the money even if in small amounts over a long period of time.

THE SERVICE DELIVERY SYSTEM

The focus of this section is on description of both the agencies which deal directly or indirectly with child abusive/neglectful families, i.e., the legal and service context in which CTC operates, and of the linkages between CTC and these agencies.

California law requires that all abuse cases be reported to the police department and the probation department within 36 hours. Cases may, if an individual prefers, be reported to the county welfare department or to the county health department, which in turn report to the police and probation department. This system of options has the advantage that certain categories of reporting individuals, e.g., school nurses, feel much more comfortable and are therefore more likely to make a report to the county health department than to the police.

The probation and welfare departments are actually both components of the Human Resources Administration, which is in the process of decentralization. Abuse cases are currently handled by probation officers assigned to the welfare department. Upon decentralization, this will become a welfare function, undertaken by welfare staff. Child abuse and neglect have been a major priority within the agency for many years, as exemplified by the fact that, traditionally, the best trained workers have been assigned to child protection services. Approximately 1,000 suspected cases of abuse and neglect are reported each year, of which 273 were valid in 1974 and reported to the State registry.

Child abuse is also a priority within the police department and the county health agency. At least some staff in each of these agencies has had some training in child abuse and at least one person is assigned full time to child abuse.

Voluntary agencies such as the Children's Home Society and the Parental Stress Center also provide services to abusive parents. The emphasis of both these programs is on prevention of abuse through placement of the child, through temporary or emergency care, and through counseling for parents.

Through the Advisory Board, through its speaking and training engagements in other agencies, through the interagency case management conferences, and through the active efforts of its director to be in contact with administrators in other agencies, CTC has had a major impact on the service delivery network in both the public and private sector. Administrators and directors of every agency at which CRA conducted interviews stressed the impact that CTC has had on community and professional awareness of the problem. Most of them also expressed their regret that CTC was devoting so much time and staff energy to training that it was less available for referrals and treatment. In the past few months CTC has had to restrict its acceptance of referrals to the hospital and to self-referrals. Other agencies have become aware of this restriction and staff at these agencies have expressed considerable regret at what they perceive as the curtailment of an excellent service. The hospital also perceives a curtailment of CTC services, but of a different sort. CHMC staff regret that the California-wide training responsibilities of CTC prevent the intensive concentration on hospital physicians which used to characterize CTC efforts. It is felt that there is a whole new group of physicians and nurses which CTC is not reaching, who need to be sensitized to issues surrounding identification relating to both abusive and high-risk parents.

In any event, staff at all of the agencies regret CTC's other training commitments because they feel that CTC has played such an important role in the community. The impacts discussed by staff at other agencies can be characterized as follows.

- Training staff at agencies in Alameda County, e.g., CTC trained the child abuse team within the public health agency both in case conferences and group therapy techniques and has provided training to staff at virtually all of the agencies interviewed.
- Facilitating relationships among agencies which traditionally have had little or no positive interaction, especially between CHMC and the mandated public agencies, and between the social service and health agencies on the one hand and the law enforcement agencies on the other. For instance, the police department reports that CTC has played a definitive role in facilitating the relationship between the police and CHMC, including setting up a system whereby hospital records are made accessible to the police department, following the signing by the parents of a CTC-designed waiver. Similarly, the Human Resources Administration reports that CTC

has facilitated its relationship with the medical staff.

- Sensitizing the community so that reporting, particularly by professionals, has increased both because of greater skills in identification and because of a diminution in the reluctance to report. The police department, for instance, feels that due to CTC input in the community reporting has increased greatly.
- Serving as a long-term treatment facility for abusing families, which prior to the forming of CTC represented a major gap in services.
- Pinpointing service needs within other agencies. Several agencies credit CTC with spearheading the agency's child abuse efforts. For instance, the public health agency states that if it were not for CTC's consciousness-raising efforts, training, and consultation, it would not have a major child abuse program. Similarly, the Children's Home Society reports that its efforts to develop a crisis nursery and a crisis foster care program are in response to CTC advocacy efforts.

The excellent relationship between CTC and the Human Resources Administration is noteworthy and, at least in part, attributable to the fact that CTC is providing a direct treatment service rather than increasing the workload of an already understaffed public agency through additional referrals.

COMMUNITY EDUCATION AND TRAINING SERVICE PROVIDERS

This section summarizes the CTC efforts in community education and professional training.

Community Education

The director conducts approximately two professional seminars per week, e.g., in hospitals, nursing schools, medical schools, etc. Most of the lay community education efforts are centered on speeches made at schools by members of the Junior League speakers/media group. They address high school classes on the issue of parenting and have recently prepared a slide show and script to use with this age group, which describes the realities and challenges of parenthood.

In addition, presentations aimed at the general public have been given on a number of local television and radio shows, as well as in articles in local newspapers. Presentations have been given to a variety of civic groups, parent-teacher associations, and church groups.

Professional Education

Throughout its 3-year history CTC staff has been involved in training service providers in Alameda and Contra Costa Counties. In the last year, through training grants from SRS and NIMH, CTC has developed training materials aimed at a number of service providers.

As part of the SRS grant, welfare workers in 58 counties were trained in identification and case management and treatment. After 2 days of initial training, two day-long followup trainings were held at 3-month intervals at each site. It is reported that several counties have initiated special child abuse programs. The results of that training effort are currently in the process of being evaluated.

As part of the NIMH grant, four training modules have been developed.

- *Health:* This module is directed to physicians, nurses, and x-ray technicians.
- *Public Health/Social Welfare:* This module is directed to public health nurses, probation, and protective service workers and deals with issues of identification and case management.
- *Mental Health:* This module presents the CTC case management and treatment philosophy and approach. It is directed to therapists in community mental health centers and therapists in other agencies or in private practice.
- *Prevention:* This module is directed to indirect service providers, all elected officials, agency directors, and to legislative, civic, and community groups.

All of these modules have been written, experimentation with various forms of delivery has been planned, and there is to be a field test with an accompanying evaluation.

The combination of treatment and training seems to be a very important one both in terms of staff development and in terms of the validity

of the training materials. The materials have been written by people who have actual experience in child abuse and who have had an opportunity to integrate their ideas and experiences. The need to develop training materials has forced treatment staff to conceptualize and to develop criteria to a far greater extent than is usually characteristic of treatment providers.

RESEARCH AND EVALUATION

CTC has its own internal evaluator. In addition to providing evaluative data on the impact of the SRS training efforts, internal evaluation efforts have a three-pronged emphasis.

- *Client profile data*
  These data are intended to provide ongoing information on CTC clients for internal use and evaluation. The American Humane Association form has been completed retrospectively on 74 abusive and 36 high-risk families and will continue to be used prospectively.
- *Service statistics*
  Data are being kept on the disposition of cases, services received, monthly referrals, number of cases actively in treatment, etc.
- *Impact on clients*
  The evaluator is exploring the use of Goal Attainment Scaling as a technique for evaluating the effectiveness of treatment modalities. Using this technique, it is planned that therapist and client will set specific goals and that progress toward achievement of these goals will be evaluated periodically. The intention is to evaluate the effectiveness of different modalities, although this may prove difficult because of nonrandom assignment of clients and the use of at least two modalities for many of the clients. Alternative ways of counteracting the effects of nonrandom assignment are being explored.

Based on current data, it is known that the reinjury rate is only 2.2 percent among clients who are in treatment. During the past 2 years, only three children known to CTC have been reinjured: one was a high-risk case, one was an abuse case in treatment, and one was a case in which CTC had provided consultation only. Thus, children were reinjured in only two treatment cases; in one of these cases the mother had been missing appointments and a conference had been called to set limits. It is not known what proportion of children are not in the home throughout this time, nor is it known what percentage of cases are lost in followup.

SUMMARY OF KEY FEATURES

CTC is a complex multifaceted program which demonstrates what a hospital can do with additional funds targeted to child abuse. The treatment program itself, with its flexibility in terms of providing individual, couple, and group therapy for adults as well as child therapy is unique. In addition, CTC provides a multiplicity of supportive services, some of which are highly innovative, such as the child enrichment program, the special trauma clinic, and the client emergency fund. Therapeutic services are intensive and tend to continue for a period of 2 years or more. The payoff is the reinjury rate of 2.2 percent, which is extremely low.

Another striking feature of this program is the extensiveness of its local efforts in terms of developing linkages with other agencies and providing community and professional education and consultation. Through a well-developed volunteer program, CTC is able to extend its community education efforts to include an education for parenting in the high school component.

One of the great strengths of this program includes the triple focus: on treatment, on the development of training materials, and on training. Each of these activities has enriched the activities in the other two areas. The enthusiastic reception of service providers to the training materials illustrates the value of having training materials developed and training sessions conducted by people who have firsthand experience in the treatment of abuse.

Scan Program of Pittsburgh Children's Hospital Pittsburgh, Pennsylvania

by Monica Holmes, Ph.D., and Doris Grunspan

Program Directors: John B. Reinhart, M.D., and Sue Evans, MSW

START-UP

During the 1950s, individuals who had a marked interest in child abuse and neglect converged on Pittsburgh Children's Hospital. Dr. John Caffey, Ms. Elizabeth Elmer, and Dr. John Reinhart were preeminent in sparking the interest and concern of many fellow professionals and students and were responsible for initiating a variety of medical and psychological studies. Throughout the sixties, these individuals and their students continued to sensitize their colleagues in medicine and social services throughout the hospital to the prevalence of abuse and neglect. The present SCAN coordinator, Sue Evans, MSW, came to Children's Hospital in 1966 and participated in this "movement." By 1968, seminars on abuse and neglect were being made at grand rounds, and training was being conducted for social services staff. An informal consultation team developed, so that individuals who suspected abuse in a particular case had colleagues available to them with whom they could discuss the case and a set of procedures to follow.

Through an outreach effort at other hospitals, awareness of the consultation services available at Children's Hospital spread so that other hospitals began to make requests for such consultation. By late 1972, it became clear that Children's Hospital needed a specific program which could address the needs for consultation, for collaboration with other agencies, and for training of relevant professionals. Following a visit to the Denver Program, the chief of psychiatry and the social worker who later became the SCAN coordinator developed a SCAN procedure and a weekly meeting addressed to child abuse and neglect concerns.

The first SCAN meeting was held in January 1973, including only medical and social services staff. Participation of staff from other agencies was actively pursued, but only gradually achieved. In the case of some agencies, it took approximately 1½ years to elicit full participation, which came only after the SCAN meetings proved to be worthwhile and after jurisdictional and role problems were resolved. Those agencies which did not initially participate were sent summaries of the weekly discussion which included a set of recommendations for action. All relevant agencies continued to be invited to the weekly meetings and all agencies were alerted to the fact that they could request the staffing of a case. At present, it is estimated that the ratio of Children's Hospital cases which are staffed to cases from other agencies is 3:1. Cases chosen by the coordinator for presentation at the staffing conference are chosen for their complexity, lack of initial clarity, and need for the development of recommendations to the court.

The composition of the group varies from week to week, depending on the individuals involved in a particular case and the training needs of the hospital and of the other agencies involved. Every SCAN meeting includes hospital staff as well as students. Third-year medical students are assigned for a 6-week period and nursing students are assigned for a semester. A child welfare caseworker is always present and in the past child welfare staff from neighboring counties has attended the SCAN meetings as a training experience. Neighborhood legal services attorneys, public health nurses, and sometimes the police also participate.

PROGRAM OBJECTIVES

- To provide a mechanism for information sharing and coordination concerning a single case by the various agencies and services involved
- To develop a set of recommendations to the court on court-related cases
- To provide a channel of communication for representatives from different agencies
- To provide a mechanism for teaching a variety of service providers about child abuse and neglect
- To sharpen the diagnostic and predictive skills of the SCAN consultants through ongoing experience and analysis of past mistakes

PROGRAM AUSPICE

The SCAN Program is hosted by Children's Hospital, which is a major teaching hospital and facility for the care of children. The 200-bed hospital serves a tri-state area; there are approximately 10,000-11,000 admissions a year and 110,000-120,000 outpatient visits a year, of which approximately 10 percent are emergency room visits.

PROGRAM COSTS AND SOURCES OF FUNDING

Until very recently, there has been no specific, separate funding for the hospital program. Therefore, all of the hospital staff who participate have other assignments and responsibilities. Recently, the hospital has received funding from several private foundations for the creation of a Parental Stress Center.

FACILITIES

The SCAN team has access to the full medical and social services facilities of Children's Hospital.

COMMUNITY AND PARTICIPANT CHARACTERISTICS

The City of Pittsburgh has a population of approximately 500,000. However, 60 percent of inpatient admissions and 40 percent of outpatient admissions are from out of State. Therefore, census data on Allegheny County are irrelevant and the hospital maintains only minimal demographic data. No data on outpatients are available; among inpatients, 89.1 percent are caucasian, 10.5 percent are black, and .4 percent are classified as "other." In terms of income, it is known only that among inpatients, 60 percent are covered by Blue Cross/Blue Shield and 35 percent are eligible for Medicaid or medical assistance.

There are no data on the characteristics of abusive families or of abused children available. It is known, however, that approximately 50 percent of the victims are less than 2 years of age.

THE STAFFING OF THE PROGRAM

There is no staff member who has a full-time responsibility for child abuse and neglect cases. The director of psychiatry, the SCAN coordinator, and approximately 12 of the 20 social workers in the hospital all devote *some* time to child abuse issues and cases. Each service has at least one social worker who works with abusive families as part of his/her regular duties. In addition to the SCAN coordinator, the social workers who are most heavily involved are those who staff the neurosurgery, infant, preschool, and surgery floors; the department of welfare liaison worker within the hospital; and the outpatient/emergency room worker.

The majority of these individuals have an MSW; most have had more than 5 years' experience and they can be characterized as an unusually knowledgeable and experienced group. With regard to abuse and neglect, they have a clear understanding of the steps, processes, and issues involved in identification, reporting, and case management, including court testimony, referrals to other service agencies, etc.

DIRECT SERVICES

IDENTIFICATION

Identification of child abuse within the hospital has risen dramatically from 7 cases in 1967 to 230 cases in 1974. The house staff is reported

to be very sensitive to signs of possible abuse and neglect and renewed efforts are made each summer with new house staff. Patients admitted to the hospital as inpatients are carefully scrutinized by a vigilant and knowledgeable social service staff. Certain kinds of injuries, coupled with inconsistent stories on the origins of the injury, arouse suspicions. Skeletal surveys are made and parents are interviewed by social service staff, when possible, in conjunction with the attending physician.

The volume of children seen in the emergency room is such that the social service staff cannot check every chart. However, the emergency room staff is sensitive to the identification of child abuse and knows when to call social service staff for consultation. Except in the case of emergency room physicians, who rotate from other hospitals, staff is relatively certain that child abuse cases do not go unnoticed or unreported.

The several physicians and social workers who make up the SCAN consultation team are available for consultation to anyone who suspects a case of abuse and neglect. Consultation can center around review of information gathered to date, on whether or not a SCAN report is warranted, or on how to approach the parents.

Once it has been decided that grounds for suspicion exist, a SCAN report is made orally to child welfare, followed by a written report within 48 hours. Each month, the medical director, the hospital administrator, and the director of the hospital poison center receive a list of all cases reported by SCAN. Record room personnel stamp all records with the SCAN stamp so that in the future it will be possible to check whether suspected cases are already known to the hospital in relation to a previous injury.

CASE MANAGEMENT

For children admitted to the hospital, case management usually rests with the social worker on the service to which the child is admitted. All caseworkers functioning in this capacity are prepared to offer social evaluation, short-term counseling, referral to other agencies, consultation to other agencies, and participation in court testimony. Once the child is discharged, efforts are made to maintain some contact with the mother through the outpatient clinic. Several social workers have kept in touch with clients over a period of years in this manner. The SCAN coordinator has maintained several clients in a long-term casework relationship.

In all cases, social evaluation includes an extensive social history of the mother and father. In some cases, psychiatric and psychological evaluations of the parents and of the child are conducted through the psychiatry clinic. This effort is aimed at developing an understanding of the environment in which the child lives and of the potential offered by that environment for reinjury to the child. On the basis of this assessment, and of reports of mother-child interaction made by nurses and social workers, the social worker estimates the degree of risk which would be associated with the child's return to the home. These estimates are then discussed at a SCAN meeting or, in the absence of a staffing on a particular case, with the child welfare worker. In some cases in which there is a possibility that the child will be placed with relatives, the hospital social worker also becomes involved in a social evaluation of the relatives.

Hospital social workers make referrals to infant stimulation programs and to day care on behalf of children who are returned home. Similarly, referrals to mental health and casework agencies are made in order to engage mothers and older children in treatment.

Coordination with other agencies, particularly with other hospitals, is emphasized. Relationships between social services staff at Children's Hospital and social services staff at the nearby maternity hospital result in some very close case-centered coordination. When staff at the maternity hospital become aware of a woman who has had no prenatal care, who seems unable to relate to or adequately care for her baby, and who has no support system available, social work staff at Children's Hospital are notified. In these cases, the Children's Hospital social worker visits the mother at the maternity hospital in order to introduce herself and to establish a contact; a clinic visit is scheduled for the 5th day postdischarge, the mother is seen at subsequent weekly visits by the same social worker and a single pediatrician is assigned who follows the baby at all visits. In this manner an effort is made to create a system of support around a high-risk mother in the hope that, if she gets into trouble, she will see the hospital as a friendly place to which she can come for help. It is estimated that the maternity hospital makes five to six such referrals each month and

that some tragedies have been averted through these case management procedures. The following case serves to illustrate this point.

Connie came to the outpatient department of the maternity hospital 8 months pregnant having received no prenatal care. The staff there was concerned because she spoke of her fears that her baby would be bad and that it would end up like its father who was in jail. Connie had been abandoned by her parents, had no network of relatives or friends on whom she could rely, and exhibited considerable strange ideation. A Children's Hospital social worker went to visit her just prior to the time she gave birth and set up a clinic appointment for the 5th day of the baby's life. During this first appointment, Connie complained the baby wasn't eating well and behaved strangely. The social worker told her she could call her at any hour of the day or night if she experienced any difficulties. Shortly after, she came to the hospital in the middle of the night saying that the "baby was dying" as she had given it a severe shaking to ensure breathing. It is quite possible that her feeling of connectedness to the hospital saved this baby's life.

Consultation on cases is provided to child welfare and to juvenile court. In response to requests from these agencies, social and psychological evaluations are performed by hospital staff.

In response to the difficulty of developing recommendations for the court as to whether or not a child should be at home or in placement, and as a result of disagreements in which child welfare has favored the return of the child and the hospital has favored placement, the hospital, child welfare, juvenile court, and the Child Guidance Clinic have received support for a Parental Stress Center. The purpose of the center is to provide an environment in which the child can be protected and the parenting capabilities of the mother can be evaluated. The center is housed in the Children's Home which has made space for five babies who will be referred to the center from the court. While the infant is living in the Home and being cared for by the Home's nursing staff, the mother (or parents) will be brought into the center on a regular basis to participate in an intensive diagnostic and short-term treatment program. Understanding that it may be difficult to bring mothers who have other children at home into the center, the center has begun to make arrangements for transportation and for a sibling nursery staffed by volunteers. At the time of the site visit, the center was not yet operational. A director had been hired and was supervising facility renovation and recruiting staff. As soon as a program nurse is hired, the center plans to accept its first baby. It is expected that in the first year, six babies will be served by the program. The number of families/children served per year should increase when the program is fully implemented, as the estimated treatment time per family is 3 to 6 months. It is anticipated that during this time it will be possible to determine the mother's potential for a mothering role while giving her an opportunity to learn about her baby, to receive assistance and support for herself, and to develop a network of supportive relationships.

TREATMENT

With few exceptions, Children's Hospital staff does not provide long-term treatment for abusive families and/or children. Hospital social workers have enormous case management responsibilities for inpatients on their services; with a constant influx of new admissions, long-term treatment is simply not feasible. The psychiatry clinic handles a few long-term cases but most of the abused babies are less than 2 years of age and the clinic is set up for treatment of older children and their parents. Since 2-year-old children cannot be seen in psychotherapy, most families do not meet the criteria of the clinic.

There is one short-term treatment approach which is particularly interesting and warrants description. Two social workers run an 8-week mothers' group on the preschool floor. The groups generally have six to eight members and meet once a week for 1½ hours. A few individuals in these groups have been abusive mothers. To date, there have been four such groups; the first was highly structured, including many presentations of educational materials and seeking to teach mothers something about child development so that they could be more realistic in their expectations. Experience with the groups has convinced the social workers that education is not enough and that people have to be encouraged to express their feelings. Consequently, the last two groups have included much more free discussion with an emphasis on the sharing and expression of feelings. The goals

of the group meetings are as follows: (1) to give mothers an introduction to the helping professions without forcing them into a long-term therapeutic relationship which they may reject based on a lack of experience and knowledge, or fear, and (2) to give mothers some opportunity to develop a supportive network through the exchange of telephone numbers and friendly interaction in the group. Although no systematic followup has been done, it is estimated that one-half of the mothers have gone on to become involved in more intensive therapy and two have accepted referrals to Parents Anonymous.

As a followup to the short-term efforts of hospital staff, referrals are made to mental health facilities. Most of the social work staff report that they have not seen good results as an outcome of these referrals. Through discussions with hospital social workers, review of many cases, and interviews with mental health staff, the following constraints to treatment of abusive families in Pittsburgh have been identified:

- Mental health agencies do not have any special training for their treatment staff or special staff assigned to child abuse cases.
- Families are expected to maintain sustained self-motivation; mental health and child guidance facilities do not do outreach or followup on missed appointments and home visits are not made.
- The clinics provide no direct services, although such activity has been identified by many as an important aid to engaging abusive families in treatment.
- Mental health practitioners, if they are not well versed in child abuse dynamics and treatment, tend to feel that they should preserve the therapist-patient confidentiality, a step which is not only illegal, but, many feel, countertherapeutic.
- Mental health practitioners work in isolation, whereas abusive parents often require relatedness not just to one therapist but to a whole institution in which they feel they have relationships with a whole variety of people who like and support them.

Careful review of the situation suggests that even if clinics *had* special treatment units for abusive families, *did* outreach, and *provided* direct services, there would still be two problems which are difficult to resolve. It is apparent that at the time of identification, when the family is in acute crisis, is the very time when they seem most reachable. Thus, the social worker who makes the initial approach is in the best position to establish a caring, trusting relationship with the family. Later transfer to another therapist at another agency is risky and sometimes unworkable. The second difficulty lies in the isolation of the mental health therapist from staff in other agencies. Because of this isolation, the positive countertransference of the therapist, necessary to the treatment, is unchecked and may cloud the judgment of the therapist as to the parenting capabilities of his client. Several cases were recounted in which a psychiatrist from an outside agency reported progress in treatment of his client and, based on this progress, testified in court that she was ready to have her child in the home. Without access to firsthand observations of the mother-child interactions which showed that the mother, regardless of progress in her own treatment, was not able to adequately care for her baby, serious mistakes have been made. In several cases, based on psychiatric testimony, the baby has been returned only to be brought to the hospital "dead on arrival." Such isolation and its consequences can best be avoided through ongoing case-specific coordination between agencies.

Most of the abusive parents identified receive no treatment. Families in which there is a child at home are followed by child welfare staff, but not in treatment; parents whose children are removed are not even followed by child welfare. Hence, there are many parents who receive no treatment or interventive maintenance.

THE SERVICE DELIVERY SYSTEM

As the locus of SCAN meetings, Pittsburgh Children's Hospital acts as a coordinator of community services active in the identification and management of abused children and their families. This section provides an overview of those agencies which are likely to become involved in services to these families.

According to Pennsylvania law, cases of child abuse are reported to Child Welfare Services (CWS). In 1974, CWS received 233 mandated reports of which 93 were made by Children's Hospital; this year, CWS is receiving reports at the rate of 30/month. These figures represent *mandated* reports, i.e., reports of abuse from physicians and school personnel, and therefore

provide an underestimate of the incidence of abuse in Allegheny County. It is estimated that in addition to these mandated reports, CWS receives 300-400 calls per month reporting acts of omission and abuse.

With an estimated staff size of 130 caseworkers, CWS is mandated to receive reports of abuse, investigate reports within 48 hours of receipt, and provide protective services to abused, neglected, and otherwise "needy" children. In 1974, CWS was serving a client population of 6,582 children. Of these, 3,139 were either in foster homes (1,187), adoptive homes (52), institutions (374), or the temporary shelter (131) administered by CWS; 3,443 children were served in their own homes.

Once a child is determined to be in need of protective services, CWS assumes responsibility for case management, which includes an evaluation of the need for placing the child out of the home; placement, including court involvement, if indicated; referral to nonprotective type services; and periodic home visits by CWS caseworkers. The assistant director of CWS estimates that a case assigned to a protective service worker remains open at least 1 to 3 years if the child is in his natural home. When the child is removed from the home, CWS keeps the case open during the entire period of placement. Generally, home visits to children in placement are less frequent than to children at home; this is true in the respective cases of the parents as well.

While child abuse is a priority within the agency, work with abusing families represents only a small portion of the agency's efforts. For CWS, neglect consumes a far greater portion of staff time. According to the director of CWS, almost every case with which the agency works may be called neglect if there is something "inadequate" in the home situation. However, CWS has made special efforts in the area of child abuse: the agency is a member of the consortium sponsoring the Parental Stress Center; the director of CWS has participated in training sessions coordinated by Ms. Elmer of the Child Guidance Clinic; and CWS sends a worker to SCAN meetings at Children's Hospital whenever a particular caseworker's family is being staffed.

The Allegheny County juvenile court legal system is highly involved in cases of child abuse. The justices of the court were prime movers in the development of the new Parental Stress Center. Five years ago, juvenile court Judge Tamilia approached Dr. Reinhart and Ms. Elmer with his concern regarding the large numbers of very young mothers referred to court for abuse of infants. Knowing that the likelihood of these infants growing up to abuse their own children was great, the Judge worked with Dr. Reinhart and Ms. Elmer to devise a program which might help to break this cycle. Once the idea was born, the three juvenile court judges worked with the consortium to write a project proposal and seek funds.

In addition to their involvement in the Parental Stress Center, the judges have made some innovative decisions and taken some unusual steps toward facilitating the legal procedures for cases of abuse and neglect. In most cases of abuse that come to court, the decision to be made relates to the need for child placement. While the judges are mandated only to make a disposition regarding the child's placement, they have made it a practice to receive recommendations on the types of care and treatment that would be needed by the parent if the parent were to be given permission to maintain the child. These recommendations are then strongly urged upon the parent with the implicit understanding that they are necessary if the child is to be returned to the home. In a similar vein, the law is ambiguous regarding review of abuse and neglect cases. However, the judges make it a practice to follow each case until placement has been effected. In addition, they are amenable to keeping cases open so that each point of the decided "treatment plan" can be monitored for implementation. Finally, in interpreting the present Pennsylvania child abuse law, the judges decided that each child whose case comes to court would be assigned legal representation. Prior to this decision, the rights of the child were advocated for by a Child Welfare Services attorney; now the parent, CWS, and the child are represented individually. This system of representation is believed to be unique in the State.

The responsibility to represent dependent children in court was assigned to the central office of the Neighborhood Legal Services Association (NLSA) in 1972. NLSA is a county-wide program; neighborhood offices supply attorneys for parents while the three lawyers in the central office represent only children. When the central NLSA office was designated the office for children, the attorneys were

unprepared for the assignment. As one lawyer explained, their position was difficult because representing deprived children entails a knowledge of psychological, medical, and environmental factors that are extremely complex and that cut across a number of fields in which most attorneys are not, and generally need not be, experts. In order to prepare for their first cases, the attorneys not only read court cases, but read volumes and journals on child development and child psychology, consulted with experts in the field, and attended the Children's Hospital SCAN meetings. At first the lawyers looked on the SCAN meetings more as an educational seminar than as a point at which case information could be obtained. Now, the attorneys continue to attend these meetings when their cases are being staffed and use materials discussed during the meetings to plan their recommendations to the court. After 3 years of representing children, the NLSA attorneys speak easily and knowledgeably about such things as developmental lags and cite references in the latest journals on child development, care, and education as well as law.

In addition to representing children in court, the central NLSA office has assumed responsibility for acting as a monitoring/coordinating agency. Before going to court on a case, the attorneys try to consult with the parents' lawyers in an effort to develop a comprehensive plan which will provide care for both parties; the child's attorney meets with representatives from Child Welfare Services to encourage them to develop a complete and workable treatment plan; and NLSA lawyers request that judges continue cases, by review, so that they can be certain that treatment plans are being implemented.

While Children's Hospital is the single largest reporter of child abuse in the county, there are other hospitals reporting cases in the area. At Allegheny General Hospital, approximately one case of abuse per month is reported. Staff at Allegheny Hospital have received consultation from the intrahospital SCAN team regarding identification of suspected abuse and someone from the hospital attends Children's Hospital SCAN meetings if an Allegheny case is being reviewed. In general, this hospital has no special programs for identifying or treating abused children and their families; however, they do feel that their large outpatient service and their special services to neighborhood schools act as preventive measures to abuse.

McKeesport Hospital, on the other hand, has developed some special programs for the identification of abuse. McKeesport also has an intrahospital SCAN team and has recently begun its own abuse registry which includes photographs of the child which may be used in court. In addition, the social service staff reviews emergency room records daily while the chief of pediatrics reviews the files 4 days per week. In an early identification effort, the social service staff makes contact with every mother who comes into the hospital's prenatal clinic. In a similar vein, nurse practitioners take social histories of all new mothers. The mother and child are then assigned one nurse in order to better ensure continuity of care and this nurse checks infants for failure-to-thrive until they are 1 year old.

The Maternal and Infant Care (MIC) Project of the county health department views child abuse as an agency priority. The project is aimed at preventing mental retardation and developmental defects in children by providing prenatal care to indigent mothers and preventive care to children through the age of one. In addition to home visits by the project's public health nurses, MIC conducts 70 child health conferences per week throughout the county. These conferences, conducted by a physician and a nurse, include well-baby checkups, nutrition counseling, and developmental counseling. It is estimated that 20,000-22,000 families/year are served by these conferences which are held in church basements, community meeting halls, or any other space available in the neighborhood. The director of MIC feels that because the conferences are held in such "local" places, MIC staff is able to treat families who might not be seen in more traditional health settings. With the understanding that MIC staff may be seeing a number of "preabusing" families, the director has made special efforts to provide the staff with training in abuse. In addition to monthly inservice training provided on the district level, a psychiatrist from the department discusses two cases each month with the nurses; the director conducts quarterly inservice training sessions for the physicians assigned to the health conferences. While the project staff feel that they could be doing more in terms of wider-range treatment and coordination for abusive families, they are restricted by financial limitations. The director has developed plans for a coordinated

child abuse program within the project as well as a program within a school for adolescent pregnant girls; however, such programs cannot be fully implemented for lack of funds.

While not directly involved in the treatment of abused children and their families, the Pittsburgh Child Guidance Clinic is a key actor in the development of the Parental Stress Center. As a consortium member, the clinic has been involved with the center since the period of conceptualization. In addition, Ms. Elizabeth Elmer of the clinic has a grant to conduct preventive training sessions for professionals throughout the county. Ms. Elmer has developed a four-session training series that is presented to groups of public agency staff, law enforcement representatives, and social service personnel. Dr. Reinhart and the SCAN director of Children's Hospital, the director of CWS, and the juvenile court judges have all presented at these sessions.

None of the mental health facilities in the Pittsburgh area, including the Mental Health/Mental Retardation Base Units and Western Psychiatric Institute, provide specialized treatment services to abusive families. Families may be referred for psychotherapy, but there are no special outreach, direct, or followup services which might be necessary to motivate families to participate in the treatment process.

Pittsburgh has two 24-hour crisis hot lines and a newly formed Parents Anonymous group to which a few Children's Hospital mothers have been referred.

SUMMARY OF KEY FEATURES

Pittsburgh Children's Hospital has a strong program of identification and case management. The hospital's SCAN program clearly illustrates the importance of a hospital team comprised of physicians and social workers who act in a teaching, consultative, and supportive capacity to other hospital professionals. The presence of a hospital team increases case identification and reporting because it creates a climate in which child abuse is given consideration and in which reporting is encouraged, supported, and viewed favorably.

The program also illustrates the leadership role that a hospital can take in stimulating other agencies to coordinate services and to work in a collaborative manner. Reluctance of other agencies to participate in a joint effort can be overcome with persistence and sensitivity to the agencies' resistances. Case staffing allows input from a variety of professonals and serves both a planning and a training mechanism.

Chapter II — Private Nonprofit Agency-Based Programs

INTRODUCTION

The Bowen and SCAN programs described in this section are illustrative of the enormous variation between programs in the private sector. Both programs are committed to long-term intensive treatment for parents and both start with a conceptualization of parents as people who have intense unsatisfied dependency needs which must be satisfied before any change can take place. Both programs have received recognition for the quality services they provide and receive their entire support through contracts with the State public social services agencies. However, the SCAN program receives referrals directly from the community whereas Bowen Center receives referrals only through the public agency. The SCAN program, because of its reliance on volunteer therapists, is a relatively inexpensive program; Bowen Center with its use of highly trained professional staff is one of the more expensive programs visited.

Each of these programs has unique elements which made it particularly important for inclusion in the present study. Whereas two of the other programs visited, Children's Trauma Center and the team-based program in Laramie, Wyoming, have a parent aide program, these parent aides are considered only as adjuncts to the work of the professional therapists. In the Little Rock SCAN program, the lay therapists are the primary source of contact with the families; the program illustrates how much can be accomplished using lay therapists under the right circumstances. The SCAN collaboration with Parents Anonymous is also noteworthy.

Whereas two of the programs visited, Children's Trauma Center and the Lehigh-Northampton Counties Coordinated Child Abuse Program, include special group activities for abused children, and all of the programs encourage parents to use day care or special child care services in the community, Bowen is unique in its emphasis on children. The specialized day care program and the child play therapy program are reminders to most adult-centered programs of the importance of maintaining a perspective of the needs of children.

Both programs serve a much greater range of children in terms of age than do hospital-based programs. Both programs work with multiproblem families in which abuse may be mild or moderate as well as severe. However, while SCAN works with the entire range of abusive families in the community, Bowen works only with the most dysfunctional, most seriously disturbed and impaired multiproblem families.

Bowen Center
Chicago, Illinois

by Monica Holmes, Ph.D., and Arlene Kagle

Director: Marion Spasser, MSW

START-UP

The Bowen Center was created by the Juvenile Protective Association (JPA), a private nonprofit agency with a long-standing tradition of pioneering new casework efforts at a time when the public agency offered protective services only to the children of veterans. In order to fill this gap and in order to explore the feasibility of working therapeutically with multiproblem, neglectful, and abusive families, JPA developed the demonstration program which came to be known as Bowen Center. The center has been in operation for 9 years. From 1965 to 1971, it was funded as a demonstration program by the U.S. Children's Bureau. From 1971 until the present time, the program has been funded through a contract with the Illinois Department of Children and Family Services (DCFS).

During the past 4 years, the program has changed as a function of the shift from a Federally funded demonstration program to a State-funded operational program. With the change in funding source came major changes in services and in emphasis:

- Founded as a long-term intensive treatment program, the DCFS contract calls for short-term diagnostic evaluations and short-term treatment.
- Because the services of other community agencies were fragmented and not suited to the needs of disorganized families, Bowen was initially designed as a multipurpose center with relatively little contact with other agencies. During the last 2 years, the DCFS has sought to enlist Bowen in an effort to develop child abuse services within other agencies and to provide these agencies with consultation on program development.
- Whereas training was originally conducted only for Bowen Center staff, under the DCFS contract Bowen Center has provided considerable training for DCFS staff.
- Under the demonstration, referrals came from a variety of community agencies and institutions; under the DCFS contract all referrals must come through DCFS.
- Under the demonstration, the Bowen Center had an educational therapy component designed to assist school-aged children having reading difficulties and an on-site foster mother trained to provide short-term foster care and daily comfort to children who could not function in the day care setting; these program components no longer exist.

Throughout its 9-year history, the Bowen Center has had the same director, the same consultant, and several of the same caseworkers, so that the treatment philosophy has remained stable during the gradual evolution of the program. It is one of the oldest programs in the country with an emphasis on long-term intensive psychotherapy for both children and adults and on coordination of a variety of supportive services.

PROGRAM OBJECTIVES

- To provide supportive and long-term treatment services to parents who have never achieved an adequate level of functioning in order to help them achieve such a level
- To provide corrective, therapeutic, and supplemental parenting services to children in order to promote their development in the face of parental deficits

- To develop a model of service integration within a single multipurpose center
- To develop a treatment model which would promote ego development and functioning
- To provide training and consultation to DCFS staff in the management and treatment of child abuse and neglect
- To provide consultation services to other agencies seeking to develop services for abusive and neglectful families

PROGRAM AUSPICE

Administratively, the Bowen Center is part of the Juvenile Protective Association, a private, nonprofit social service agency. JPA was organized as an agency when a group of individuals, working with the Chicago Bar Association, served as the impetus for the creation of the first juvenile court in the U.S. The Bowen Center is housed in its own facility and because it receives no direct funding from JPA, it is relatively autonomous in its functioning.

PROGRAM COSTS AND SOURCES OF FUNDING

The budget for 1974-1975 is approximately $294,000, allocated as shown in figure 7.

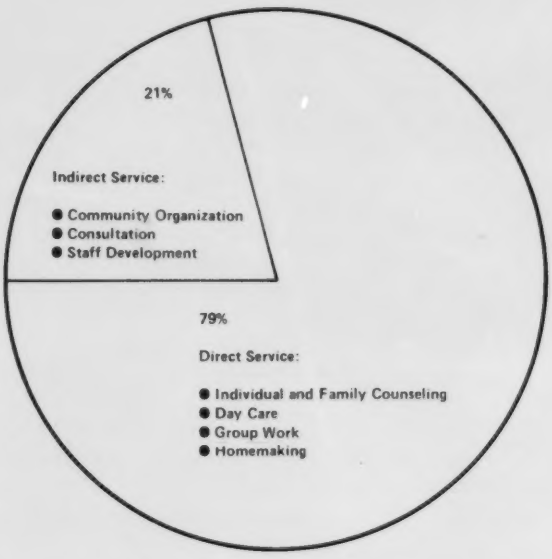


Figure 7. Budget allocation

The program receives 100 percent of its funds from the Illinois Department of Children and Family Services, which is the agency legally mandated to provide services to abused and neglected children and their parents.

FACILITIES

Bowen Center is housed in two attached houses which are equidistant from an area which is inhabited primarily by black and Puerto Rican families and an area inhabited by Appalachian families.

One of the houses has staff offices and a conference room, two large rooms for the day care program, a kitchen, and a very large room which is used by the day care program for eating and playing. The adjoining building has additional offices, play therapy rooms, meeting rooms for the mothers' groups, an apartment which is available to client families for live-in care, and a roof garden equipped for children's play.

The facilities are old, comfortable, and well adapted to program needs. The center gives the impression of a well-worn family home rather than a set of modern offices.

PARTICIPANT CHARACTERISTICS

Specific demographic data on the areas of Chicago served by the Center are not known by the program. However, data are available on the families served.

During the past 3 ½ years (July 1971 - December 1974), the initial period of DCFS funding, the center has served 98 families. Among these, 56 families were caucasian, 20 black, 13 Latin American, 2 Indian, and 7 were of other ethnic origins. Approximately half of the client families are single parent. Data on income level are not available, but virtually all of the families are on AFDC.

Families tend to be very large. Data on family size are available on 45 families, which report an average of 4.6 children per family. Four of the families have 10 children each, 2 families have 8-9 children each, 4 families have 6-7 children each, 18 families have 4-5 children each, and the remainder have 1-3 children.

The program is designed to serve approximately 35 families at any given time.

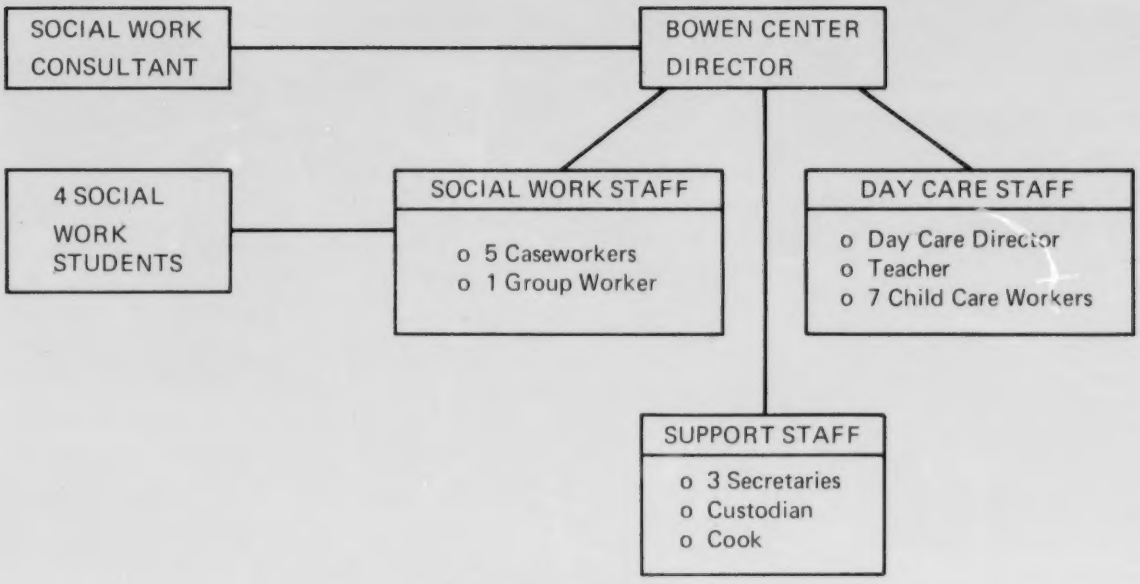


Figure 8. Staff organization

THE STAFFING OF BOWEN CENTER

Bowen Center has a staff of 21, plus one social work consultant. The staff organization can be schematically seen as in figure 8.

Director

The director provides supervision and consultation to the staff and provides some direct service to families. In addition, she spends two mornings each week at DCFS offices providing consultation to workers in the abuse and multi-purpose units. She has been the director of the center since its inception in 1965. She has an MSW and 25 years' experience. Most of ther pre-Bowen experience was in child guidance.

Social Workers

The five social workers have primary responsibility for coordinating services and for providing psychotherapy to families. One of the social workers is a group worker, but several caseworkers also have responsibility for leading the mothers' group. Caseworkers also have responsibility for supervising the social work students and for working with a child in psychotherapy. One caseworker specializes in child therapy and does all the diagnostic work on children and either supervises or carries all the child therapy cases herself.

Caseload sizes vary depending on whether the caseworker has supervisory responsibilities and community education responsibilities. Social work students work with three families each and senior staff works with no more than five families.

Four of the five caseworkers have an MSW and between 2 and 7 years' experience. Two of them started at the Center as social work students 6-7 years ago and have remained ever since. One of these is currently enrolled part time in a social work doctoral program, the other is in training as a child analyst. By background and training, the social work staff can be characterized as having a deep commitment to intensive long-term psychotherapy and as being identified more with a mental health than with a social service orientation. By and large, their experience is in private treatment agencies rather than in public social service agencies.

Day Care Director and Nursery School Teacher

The day care director is responsible for planning and supervising the overall day care program.

The nursery school teacher works with the oldest day care group.

The director has an MA in education and 5 years' experience at the center; the teacher has a BA and has been at the center for nearly 9 years.

Child Care Staff

The child care staff works with the children in day care. Five of these individuals have BA degrees and two have Masters. Their experience in child care ranges from 1 year to 25 years.

A great deal of emphasis is placed on quality training and supervision of the casework staff. Dynamics of cases are discussed in great depth, diagnostic assessments are made, and the staffings on both children and adults represent intensive efforts to review and plan for both new and old cases. The use of the program as a social work student field placement adds to an atmosphere in which conceptualization and indepth understanding are valued.

Staffing conferences are held weekly, attended by the social work staff and the social work consultant. At these meetings, individual families are discussed in considerable depth. Cases presented are carefully prepared and in each case an effort is made to assess the individual's place along the developmental continuum.

The staff has, by and large, worked together for most of the center's existence and the presence of a mutual support system is readily apparent.

DIRECT SERVICES: ADULTS AND CHILDREN

Services to Adults

The following services are available:

- Individual diagnosis
- Casework for adults
- Group work with mothers

DIAGNOSIS

All center cases have been referred by the East and North District Offices of the DCFS. Cases are referred to the center director at her weekly meetings with staff from each of these offices. Once the director reviews the material with DCFS staff and it is agreed that the family should be seen at the Bowen Center, the family is referred to the center for evaluation. Either the family is transported to the center or a caseworker visits them in their home. As part of the evaluation process, the children are often brought into the day care program and their ability to relate to materials, to other children, and to adults is carefully assessed. Mothers, and only rarely fathers, are brought into the center for discussion which typically centers around their specific short-range needs. The diagnostic process takes approximately 6 weeks to 3 months.

CASEWORK FOR ADULTS

The Bowen Center treatment philosophy is grounded in certain aspects of an ego psychology framework. Abusive and neglectful parents are essentially seen as extremely immature and dependent, fragmented people who have never, in most cases, experienced a higher level of ego integration. In addition to the fragmentation, the primary ego deficits are defined in terms of impulse control and object relations. Having never achieved a positive symbiotic relationship, the conceptualization is that these parents are mired in a negative symbiosis and have never achieved separation or individuation. The negative symbiosis is then reexperienced in their relations with their children, to whom they cannot relate as separate individuals. Consequently, the primary therapeutic goal is to meet the needs of the parents with the expectation that if this reparenting process is successful and the parents' needs are met, they will then be more capable of meeting the needs of their children. Thus, the therapy is primarily addressed to meeting parental needs and helping them to achieve a close dependent relationship with staff at the center. There is relatively little emphasis on modeling new behavior or on addressing the organizing, planning, executive functions of the ego.

The therapeutic effort can be best characterized as supportive with an emphasis on exploring feelings and areas of tension. Behavioral changes are not emphasized, clients are not generally given therapeutic assignments, and therapists do relatively little confronting or interpreting of behavior.

It should be noted that in many of the families, the parents are seen as so lacking in resources as to be permanently incapable of providing even minimal care for their children. In these cases, the center seeks to provide the children with the stimulation and physical and emotional care that they lack at home. These center-raised children are permitted to remain with their psychotic or

severely retarded parents not because there is any expectation that the parents will become substantially better, but because it is felt that the center can provide enough quality care to offset the damaging effects of the in-home care. However, in cases where the child is perceived to be in danger or where the parent has virtually no attachment to the child, placement is sought. Conceptually, placement is viewed as a last resort and not as a way station on the road to parental improvement. Once placement has been effected, the thrust of the treatment with the parents is on helping them to relinquish the child and to make gains for themselves. It is felt that some parents are aware of the need for their children to be in placement because of their inability to provide even minimal care, but that the children fill an intolerable void in their lives which makes them unable to let go. The aim in these cases is to fill this void with center activities and with the relationship to the caseworker to allow the parents to accept placement for the children.

Individual contacts are usually held once a week at the center. Caseworkers are responsible not only for treatment but for all of the case management functions. Thus, they arrange transportation, accompany clients to medical appointments, assist clients with housing, with job placement, and with other concrete service needs.

Because of the massive ego deficits and the high incidence of borderline cases, treatment is conceptualized as a long-term process. Several of the families have been in treatment for more than 7 years. The center staff feels that they have been able to improve functioning in some families and that they have demonstrated families' acceptance of treatment if the response to their needs represents an all-out outreach effort.

GROUP WORK WITH MOTHERS

The center maintains two groups, each of which has approximately eight members, meeting for two 3-hour sessions per week. Meetings occur in the morning, ending just after lunch, which the members eat together. Led by the group worker and a caseworker, the groups are designed primarily to offer the mothers a socialization experience. Participants are provided with transportation and babysitting services at the center. Each group engages in a variety of craft activities and in some discussion. The group can best be characterized as a recreational activity group rather than as a traditional therapy group. Group leaders provide the mothers with concrete activities, the completion of which provides a sense of pride in achievement. Self-esteem is increased through these activities, through emphasis on personal grooming, and through the attention which is paid to each mother on birthdays and other special life events. The members have no contract to discuss or to work on their problems during the meeting; rather the meetings are a time for them to relax, socialize, and enjoy themselves. Socializing among members outside of the group is not encouraged as it is felt that the mothers tend to reinforce each other's pathology.

Once a month the center holds a "parents night" to which all ongoing families in treatment are invited. This event consists of dinner and some group activity. Food is prepared by the mothers and by the staff and the emphasis is on family interaction and enjoyment.

Services to Children

The center offers the following services:

- Day care and after-school program
- Play therapy

DAY CARE AND AFTER-SCHOOL PROGRAM

There are three groups in the day care program: 2- and 3-year-olds, older 3- and younger 4-year-olds, and a group of 4-, 5-, and 6-year-olds. The ratio of staff to children is approximately one to three. The center is licensed for 30 children. The children are picked up by the staff each morning and returned to their homes each afternoon. Often, when the staff arrives, the children are not dressed. These children are dressed by the staff and are brought into day care. Children who are not feeling well are brought into program anyway as it is felt that they will receive better care including medical attention, if necessary, at the center. The program begins at 9:30 a.m., but all of the children do not arrive until about 10:30 a.m. As children arrive they are offered a breakfast of milk and cereal. Throughout the morning they participate in arts and crafts, concept games, and manipulative games. Before lunch there is a group story or music. After lunch the

younger children nap; the older children, who at this point are joined by three children who attend morning kindergarten, go to the roof playground and participate in active physical activities. Following the nap period, the children are served a snack and engage in more play. At approximately 2:30 p.m., the children leave the center to go home.

The center tries to work with public schools in the area and several first grade teachers have come to the center to talk about particular children known to the day care program. This kind of coordinating effort helps the teachers to better understand the needs of the children and how best to approach them.

Upon entry into the program, the children are characterized by their lack of verbal skills, their prolonged and intensive temper tantrums, their inability to use adults for comfort, their inability to derive pleasure from anything, their inability to use toys or materials, and their extreme aggressiveness toward or withdrawal from other children. The day care program is primarily designed to help these children develop a trust relationship, to facilitate their individuation and sense of identity, and to improve their level of personal, social, and communicative skills.

The high staff to child ratio is seen as necessary because of the extreme pathology of the children, who require massive emotional and physical care. Many of the children take a long time before they are able to join the group; these children are assigned a full-time worker who stays with them, comforts them, and tries to meet their needs for an intense parenting relationship. Some of the children are bathed and provided with clean clothing at the center.

After-school activities are provided 4 days a week for older children. There are four such groups: 5-6-year-old boys and girls, 7-8-year-old boys and girls, 9-11-year-old girls, and 9-11-year-old boys. Each group has approximately five children and meets twice a week. The groups are designed to give the children a positive socialization experience with an emphasis on the development of inner controls. The children are picked up at their schools, engage in recreational activities, and are then delivered to their homes. Whenever possible, children in placement continue to be seen at the center so that they may have a continuous relationship and in order to help them with the negative behavior which so often makes these children unmanageable in one foster home after another.

PLAY THERAPY

Children past the age of 3 who do not show sufficient progress in the day care program and who are identified as having especially severe problems are seen in play therapy either two or three times a week. The focus of these sessions is to help the child deal with, express, and work through the anxieties and fears that are interfering with his development. The aim of the play therapy is to provide the child with a positive symbiotic relationship so that, ultimately, individuation and separation can be achieved. The conceptual focus is on ego development, encouraging the child to move from a presymbiotic infantile level of development to an age-appropriate one. The child's needs are gratified, feeling states and anxieties are interpreted, and every effort is made to provide the child with the model of an adult who is consistent and giving.

In general, staff feels that the changes seen in the children are more dramatic and more far reaching than are the changes seen in the adults.

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In the cases that follow, two reflect Bowen Center treatment of total families and one reflects treatment of a child. These cases are intended to illustrate the center philosophy and techniques of treatment.

Janice and Lenny

The parents and three children which comprise this Appalachian family were referred by the Board of Health in the fall of 1968 for failure to follow through on clinic appointments and for inadequate nutrition.

The mother, Janice, is one of five children; she experienced a chaotic and unhappy childhood. Her mother is characterized as mentally ill and it is reported that she tried to kill Janice and her brother in infancy. Despite this behavior on the mother's part, she was also apparently deeply symbiotically attached to her children and thwarted all of their efforts to grow up or to move out of the house. In order to escape this situation, Janice married her first husband when she was 19. She stayed with him until he died 10 years later; her one child from this marriage is retarded and lives with Janice's mother.

The father, Lenny, also comes from a family of five children and grew up on a farm in extreme

poverty. He married his first wife at the age of 17 and one day, in a rage, shot and killed his father-in-law. He then spent 10 years in prison, during which his mother came to visit him four times. He has always had a bad temper; one of his brothers is permanently disabled from a beating Lenny gave him.

Following his impregnation of Janice's sister, Janice and Lenny were married and soon after came to Chicago. Lenny worked sporadically and whatever money he did make was spent on himself rather than on his family.

Initially, the family was visited by the social worker in the home and most of the contacts were with Janice. The children were seen as unclean and poorly fed, the one and one-half room apartment dirty and unkempt, and Janice was characterized as unrealistic and somewhat bizarre. Early contacts with the mother focused on helping her to obtain public assistance and medical care, inviting her to join a mothers' group and taking the two older girls into day care. The children invariably had to be bathed in day care and to have their clothing washed and changed.

Janice was assigned a student who worked with her for approximately 7 months. During this time she formed a very dependent relationship and was able to have some of her basic needs gratified. As she began to trust her worker, she was able to talk about the beatings with a strap that Lenny gave the children. The beatings did not result in serious injuries, but the children did appear to be very frightened. She also began to describe her husband's relationships with other women, particularly his continuing relationship with her sister.

When the student left, Janice was assigned to a case worker who continued to work with her for the next 6 years, continuing until the present time. There was apparently little difficulty in this transition from one worker to another and Janice continued to be able to talk about her problems and her history. Lenny continued to be uninvolved in the treatment.

When Janice was hospitalized for eye surgery, the children spent the week at the Bowen Center in its foster home. Although Lenny, at this time, took whatever money was available and left town with his friends, and Janice suggested to the worker that she might leave him, the worker told her that she should delay that decision until they had some understanding of what went on in the marriage. This lack of intervention was important because Janice had no intention of leaving Lenny and was merely verbalizing what she thought the worker wanted to hear. When Lenny returned, he, too, was amazed that the worker had not suggested separation and this is reported to be the point at which he first began to relate to the worker. Soon after, Lenny was hospitalized for 5 weeks and the worker not only discouraged Janice from paying him back by disappearing, but accompanied her on weekly visits and stayed for part of each visit. Lenny was openly appreciative of these visits and when he came home, joint weekly visits were continued. These joint sessions were used to allow Lenny to begin to talk about his childhood and early experiences and to help him with his denial of feelings and of problems. The sessions were also used to discuss the problems in their marriage, which included her baiting and nagging him, his relationships with other women, and their destructive and continuing relationships with both of their families. Janice realized during this time that she had no knowledge of how to talk positively to Lenny and that they never had anything good to say to each other.

The oldest girl, Connie, was approximately 3 ½ years old when she first came into the day care program. She was described as having violent temper tantrums, unable to tolerate any kind of routine, and unable to relate to adults. She was provocative, aggressive with the other children, and represented a marked behavior problem. Her 2-year-old sister, Jean, was characterized by extreme frailty, fearfulness and poor motor coordination. Both girls were nonverbal and showed signs of severe neglect including a multitude of bruises and sores on their bodies.

During their first year at the center, both children developed some speech, began to relate to a single adult, began to eat, and Jean was toilet trained. However, any change in her routine still caused her to withdraw under a table. Staff devoted a great deal of attention to both children: they were bathed, cuddled, and given a great deal of physical contact. As they could not tolerate nap time, this was used as individual quiet time for each of them.

Individual treatment for Connie was initiated after her first 10 months in day care because it was felt that she had not made sufficient progress in terms of the development of a trusting relationship. When she first started treatment, she was unable to tolerate a session for more than 10 minutes. She was suspicious, anxious, and frequently ran away. Once she began to establish

a relationship with her therapist, she experienced great difficulty in handling this relationship while maintaining the one with her special worker in day care. At first she was unable to tolerate both workers being in the same room and repeatedly tried to reject one or the other. Gradually, she came to accept what she was repeatedly told, that it was all right to have two friends. Her repeated attacks on the staff were handled with firmness but with a great deal of emotional warmth reassuring her that everyone understood how bad she was feeling and that everyone liked her. A great deal of time was spent working through her separation anxiety and reassuring her that people do come back even when they leave for periods of time. Gradually she became able to verbalize her feelings of fear and to talk about the physical violence to which she had been subjected in her home.

The youngest child, Richard, entered day care at just under 2 years of age. The favored child of both parents, he had not been abused and appeared to be a large, healthy, hyperactive child. Totally unable to direct his energy to any constructive play, day care helped him to begin to relate to materials and to develop an age-appropriate attention span. He was offered considerable opportunity for active play in order to help him develop large muscle coordination and control.

Approximately 2 years after Bowen Center began working with the family, Lenny asked if they could move into the apartment at the center. The center staff decided to explore how helpful residential treatment for an entire family could be and agreed. For the next 5 years the family lived at the center.

When they first moved in, the parents' functioning grew worse in that they did not take care of the children at all. The center bathed and fed the children, sent cooked meals up to the family, and did all of the caretaking of both the children and the adults. At about this time, Janice began to deteriorate both physically and mentally. She lost 40 pounds, was bleeding and vomiting, and appeared to be extremely rundown and nervous. Finally, she was admitted to the hospital for a 2-month period and was then discharged to a halfway house. Janice spent 2 years in the halfway house and came back to her home at Bowen Center only on weekends. It is reported that she did well at the halfway house, made friends, and enjoyed the behavior modification approach which was used with her. During this time, the children were placed in foster care and Lenny, who was very lonely, spent a great deal of time with the staff.

When Janice returned to her apartment in the center, she was given a structured weekly appointment and continued to be seen in treatment for as long as she lived at the center. In April 1975, Janice and Lenny were able to mobilize themselves and find an apartment away from the center. Janice has been able to keep her house clean, she now goes to church several times a week, and still comes to the center to visit. The two younger children are having serious problems, especially Richard who is retarded and at 8 does not yet write his name. Connie, the eldest, is in a nearby residential treatment center and continues to be seen twice weekly by the same therapist who has seen her for the past 5 years.

At this point, there is a strong bond between the family and center staff such that Janice or Lenny call when they are in trouble or stop in to visit. They maintain a close tie with Connie whom they visit regularly and they also have a more supportive relationship with each other. Whereas Lenny used to carry a gun and become easily enraged, he can now be teased and it is even possible to argue with him and contradict him. Whereas he used to kill stray animals, he now brings them to the center director because he knows she likes to care for them. The staff's feeling is that Janice and Lenny have been stabilized and that they have begun the individuation process. Jean and Richard have been accepted in a therapeutic school and the center hopes to continue working with the mother and provide the family with support. The goal is to see how far the family can progress with continued support and follow through.

Josh

This family was referred to Bowen Center in 1970 by the Court of Domestic Relations. The parents were reported to be having violent fights, frequently left their three young children alone, and Josh had held his youngest daughter out of the window and threatened to drop her. He was drinking heavily and at such times became violently abusive. His wife, Dixie, was also abusive with the children; her discipline included locking a child in the refrigerator and slapping a child until its mouth bled.

Two different social workers, one for each parent, were assigned to work with them. Initially,

Josh blamed everything on Dixie saying that she drove him crazy, but he denied that he had any problems or concerns. He was totally unable to discuss or express angry feelings and would keep everything in until it exploded. Dixie was Josh's third wife and he was terrified that she would be unfaithful or would leave him. He was also afraid of what he would do to her, as he had beaten his first wife so badly that she nearly died.

Initially, Josh was totally fused with Dixie and with his children and could not recognize each of them as individuals with separate needs. His repetitive pattern was to deny his own needs in order to gratify theirs and then to become frustrated, disappointed, and finally enraged because of his lack of satisfaction.

The first year, Josh was in treatment with a male therapist and was able to form a positive relationship. When his therapist left, he started seeing a second worker whom he has continued to see for the past 3 years. During this second year of treatment he came to his weekly appointments and talked almost nonstop. He came because he had a need to talk and be heard by someone who was noncritical and nonpunitive. The therapist primarily listened, made no interpretations, and asked few questions. In his first year at the center, Josh gave up drinking although the staff feels this was something he did on his own and not because of any therapy.

Josh talked about his fears that there was something wrong with him, about his inability to read or write, and about his fears that something would happen to Dixie. He talked about his feelings of sexual inadequacy and about his fear of his own temper. He began to report incidents from his past which demonstrated the extent to which he lost control of his temper. For example, in one incident he became enraged with the dog and threw it down the stairs. Immediately afterward he felt so badly that he picked the dog up and talked to it, but it was too late and the dog was already damaged. His biggest fear was that he would lose his temper and do irreparable harm to a member of his family.

It was not until the third year with his second worker that Josh became willing to talk about his past. Up until that time he had always refused to talk about his past, saying that "what's past is past." He revealed the fact that he had been an illegitimate child and that this represented a tremendous source of shame to him. He perceived his father as abusive and felt that he never received any recognition of warmth from his mother who instead gave all the attention to his brother.

The therapy is primarily focused on his needs and his problems. By and large, the therapist does not bring up problems with the children and does not give advice. The feeling is that if the therapist demanded it, Josh might change his behavior, e.g., yelling at the children constantly, but it would only be to please his therapist and not because the change was internalized.

Josh's therapist is leaving the center in June and he will be transferred to another therapist. The marriage is at this point calmer, both parents continue in treatment, and the children are seen in the after-school groups.

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The following case describes the Bowen Center's therapeutic approach to children. It is also intended to convey the depth of pathology and the level of impairment of many of the children served.

Dierdre (DiDi)

When first seen in 1972 at the Bowen Center, DiDi was 17 months old. Currently she is approximately 4½ years old. She has a brother who is 1½ years younger than she. She and her brother live with their maternal grandmother who has five children of her own, including twin girls who are only 6 months older than DiDi and a son who is 1½ years younger than DiDi. DiDi's mother is in and out of the house and is not really the caretaker of either of her two children.

The referral on the family was made by the Board of Health because one of the grandmother's twins was a failure-to-thrive baby. The grandmother was seen by Bowen Center and was characterized as an extremely passive, dependent women who was unable to provide care for the younger children. The family receives public assistance and its life is punctuated by multiple housing, financial, and health crises. The younger children, including DiDi, began attending the Bowen Day Care Center.

DiDi attended the center for 2 years and by the time she was 3½ years old her behavior was a source of serious concern to the day care staff. Although she is diagnosed as having good intellectual capacity, at 3½ she was described as unable to relate to other children, join in group

activities, or relate to adults or use them for comfort. Her days were passed in crying and tantrums which often lasted for hours. Day care staff members were frightened by the intensity of her tantrums and dismayed by their inability to console her. Her family described her as a difficult and mean child and virtually ignored her existence when present in the home. DiDi's mother is described as harsh and rejecting and DiDi invariably came into day care in tears. Her physical care was described as "atrocious" and it is reported that she often came into day care urine-soaked from head to toe in the same clothes that she had left in the previous day.

Unable to relate to other children, she was possessive of any toys she touched and severe temper tantrums would ensue if a toy she touched in the morning was picked up by another child several hours later. Tantrums were precipitated by relatively minor events like food she didn't like, being touched when she was feeling bad, etc. Following the birth of her brother when she was 22 months old, her tantrums increased. She spent most of her day crying, kicking, screaming, and banging her head against the wall. If approached, she became more violent; if left alone, she would eventually calm herself by rocking.

A specific day care worker was assigned to her and the two of them spent two afternoons a week at this worker's home. During this time, DiDi was bathed, fed, and cuddled. Gradually the tantrums subsided and she began to make some gains. However, in January 1974, her special child care worker made plans to leave and once again DiDi's violent tantrums reappeared and would last up to 4 hours. On several occasions she had to be taken to the hospital emergency room as she became physically ill and it was thought that she might be having seizures. Testing proved to be negative and when the child care worker again began taking her to her apartment the tantrums subsided.

By June 1974, there was considerable improvement. She now engaged in parallel rather than in solitary play and at times was able to verbalize her sadness or anger without dissolving into a tantrum. When the worker to whom she was so attached left, she attached herself to the best friend of the previous worker, often calling her by the first one's name.

In the fall of 1974, it was decided that DiDi needed to be in play therapy. She was seen for two diagnostic interviews by the play therapist who then started treatment with her three times a week. The diagnostic impression is best summarized by the therapist herself.

> The most striking aspect of DiDi is her ability to merge so completely with the interviewer and feel so alive almost in a euphoric sense as opposed to her withdrawn apathetic appearance when by herself in day care. Her use of play material brought out this same theme, i.e., the infant's symbiotic tie to the mother. That her own aggression is engulfing to her as well as anyone with whom she is close is seen in the wolf who comes to "eat" everyone up. Her rage results in devouring and being annihilated and in her symbiotic relationships, this means both her and the person with whom she is merged. DiDi's state of apathy and isolation seem to be her way of defending herself against feelings of rage and the possibility of rejection which her own ego cannot tolerate and at times breaks through in the form of a tantrum. This seemed to be the case when she withdrew at the end of the second interview. It was as though she was defending herself against the pain of separation and possibly fragmenting into a tantrum.
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> Her waif-like appearance and the manner of relating in the day care is a defense which elicits much comforting and attention from adults as well as protecting her from environmental demands. That she does recognize people indicates that she does have object permanence. Her capacity to merge and trust that the adult will be benign was evident in the two interviews. This, combined with the fact that she does not appear to have built up rigid defenses makes her prognosis with treatment more hopeful. In conclusion, DiDi is a child who appears to be fixated at the symbiotic stage of development as a result of a lack of any one mothering figure in her early life and massive emotional and physical neglect, rather than battering. When merged she can use the adult ego to function, but alone her ego cannot tolerate any type of stress and she begins to fragment. The fact that she refuses to allow any adult to console her appears to be a very masochistic position in which she forces the adult to reject her and repeats the experience of object loss.

DiDi has been seen in psychotherapy for the past 9 months. The initial goal was to help her achieve a positive symbiotic relationship with the therapist. Initially, DiDi would not relate to or go with the therapist at all and insisted that her child care worker come too. After awhile she formed an intense relationship with the therapist and they began to do everything together, almost as one person. Within the context of the closeness of this relationship, DiDi began to regress. In the therapy she went back to using a baby bottle and liked to lie in the therapist's lap while having her stomach rubbed. In day care she appeared much happier and the tantrums diminished.

The positive symbiotic attachment to the worker was destroyed one day when DiDi saw her therapist in the day care setting with another child. For the next 6 weeks she was inconsolable,

had severe tantrums, refused to go with her therapist, and kept saying that the therapist should take the other child or her brother instead. The therapist continued to see her three times a week and she continued to scream, vomit, and refuse. Finally, this behavior subsided and the relationship was reestablished.

Recently, DiDi has begun to notice and point out differences between the therapist and herself and has begun to leave the therapist's lap in order to play. She has begun coming out from under the blanket that she covers herself with to sing songs and to talk to the therapist and has initiated games of hide and seek. It is thought that she is beginning to go through the first stages of separation. In day care she is now able to accept limits and no longer fragments. She is beginning to develop and play out fantasies and is beginning to talk about her feelings. At this point, there are times when she can verbalize feelings of anger.

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These cases illustrate the intensity and long-term nature of Bowen Center involvement and the therapeutic conception. In the adult therapy, there is relatively little emphasis on behavioral change as the philosophy is that such change follows from the need gratification of the parents. The children are given massive care and surrogate parenting because the parents are unable to provide such care, yet the ties to the parents are felt to be great and placement is not a treatment of choice. It is felt that, ideally, many of the children should be raised in a residential treatment center which would protect the tie to the parents but would give the children the care and stimulation that they require for adequate development. In Bowen staff experience, residential treatment is also more acceptable to the parents who do not feel that they are losing their child in the way they do when the child is placed with another set of parents.

THE SERVICE DELIVERY SYSTEM

Responsibility for abused children and their families rests with the Illinois Department of Children and Family Services. Bowen Center receives referrals from two of the four district offices: East and North. DCFS staff has caseloads of approximately 60 families per worker and families are seen approximately once every 3 months. DCFS has a very high proportion of adolescents who need help and who create problems for others because of their antisocial behavior; hence, child abuse is not their number one priority.

In the first 2 years of the contracts with DCFS, the Bowen Center provided a training practicum for DCFS staff who rotated through Bowen for 6-month periods. During the past year, the Bowen Center director has been providing weekly consultation and has recently started a series of seminars for DCFS staff. While DCFS staff feels that Bowen Center has a great deal of knowledge and experience, their basic view is that what they learn from Bowen is not useful because the techniques used by people who are carrying 5 cases are simply not applicable to people carrying 60 cases. Essentially, DCFS does not see the Bowen Center model as viable because it is too expensive and services too few families. DCFS administrators estimate that Bowen costs $18,000 a year per family and that the average family remains for approximately 5 years.

DCFS has expected Bowen Center to encourage other agencies to develop treatment services for abusive families; however, because there has been no money made available to these agencies, little has been accomplished. The mental health centers and the social service agencies have not developed treatment services for these families so that other than Bowen Center there is no therapeutic resource available.

Chapin Hall for Children is a residential treatment center that treats abused and neglected children ages 6-12. Most of their children are neglected, few are abused. Children are given long-term intensive treatment and can be sent there by DCFS. Chapin Hall and Bowen Center work closely together. Bowen Center sees placement of a child in Chapin Hall as an excellent opportunity for the child and Chapin Hall encourages Bowen to work with the younger siblings of Chapin Hall clients. While neither can make direct referrals to the other, they do make referrals to each other through DCFS.

Children's Memorial Hospital is very sensitive to child abuse cases and the hospital has an active program aimed at training staff to identify cases of abuse. There is a team which staffs abuse cases, and hospital staff does short-term counseling but basically acts as a referral source to DCFS.

Virtually all of the agencies at which CRA interviewed felt that Bowen Center is the only resource in Chicago which provides long-term

intensive treatment to clients in a manner which is responsive to their needs. Their caseload is so small relative to the magnitude of the problem in a city the size of Chicago that agencies seem to feel that Bowen has had a philosophical but not a practical impact.

COMMUNITY EDUCATION AND TRAINING SERVICE PROVIDERS

Basically, this is a clinically oriented program which has provided training to DCFS staff as already described, which does participate on the Metropolitan Area Protective Services (MAPS) Council with other agencies, but which has not extended its services to other agencies. Unlike other programs which seek to involve community agencies in their staffings, which tend to be problem-focused and aimed at disposition, Bowen Center staffings are oriented to treatment staff and to an indepth understanding, formulation of dynamics, and diagnosis.

Having started 9 years ago with the major premise that other agencies were not providing adequate services and that Bowen would serve as a multi-purpose agency providing most services under its own umbrella, the Bowen model has meant development from within rather than service coordination. Just as a development of linkages with other agencies has not been a major program objective, so a community education function has also not been developed.

SUMMARY OF KEY FEATURES

Bowen's development of a treatment and day care approach to children is especially important. The day care program and its 3 to 1 child/staff ratio demonstrates the difficulties involved in managing and helping many of these children in regular day care. The program's advocacy for placement of children within residential treatment centers rather than in foster homes, as a way of protecting the ties to the parents and obtaining quality care for children, is also important and needs to be considered. In a country which is focused on the rights of parents, little attention has been paid to the real needs, not just the marginal survival, of abused and neglected children. The Bowen Center stands as a reminder of these needs and of the extent and severity of the damage which has been done to these children.

Bowen Center has a profound understanding of parents and their extensive dependency needs. Their therapeutic orientation, which derives from an ego psychology framework, is one which centers on a long-term intensive supportive treatment relationship in which the gratification of emotional and concrete needs is primary. The therapeutic emphasis is on feelings and on working through the very early deprivation which prevents parents from experiencing empathy for their children. They stress the enormous investment, in terms of time and energy, and the very long period of symbolic parenting which they feel is necessary in working with multiproblem chronically neglectful parents.

Bowen's group program and its emphasis on activities and on socialization is especially interesting in that it stands in contrast to a group therapy approach and serves as a model for an important program component. This type of group experience is central to women who are too limited for a group therapy approach, but who need opportunities for socialization and recreation in a protected environment.

Scan Volunteer Service, Inc.
Little Rock, Arkansas

by Monica Holmes, Ph.D., and Arlene Kagle

Director: Sharon Pallone

START-UP

The Arkansas SCAN program has its roots in the 1967 passage of State legislation mandating members of the healing professions as reporters of child abuse. Stimulated by the passage of this legislation, the Arkansas Child Protection Committee was formed at the University of Arkansas Medical Center in Pulaski County.

This early committee served as the nucleus of the Pulaski County Task Force on Child Protection which was formed under the sponsorship of the 4-C Committee of the State Office of Early Childhood Development in the fall of 1971. The Task Force was comprised of representatives from the medical center, Children's Hospital, the school of nursing, social services, juvenile court, and private citizens in the community. Eventually, this Task Force became the present day Arkansas Council for Child Protection. Soon after the Task Force was formed, the Junior League sponsored a 2-day workshop by Dr. Ray Helfer who presented his outline of a community program, one component of which was lay therapy.

The informal antecedents of the program are interesting and bear recounting in that they illustrate the serendipitous fashion in which programs can come into being. In August of 1971, a few months before the Task Force was formed, the founder and present day director of SCAN, Sharon Pallone, who at that time was working with volunteers in an adult literacy program, encountered a young girl and her small child while shopping; in that encounter the SCAN program was born. The young child was so unkempt and so malnourished that she attracted Ms. Pallone's attention. The mother and child had hitchhiked from Missouri, fleeing a child abuse charge. They had no place to go and no place to stay. In subsequent months, Ms. Pallone sought help for the mother, which included taking her to the Salvation Army, her own family pediatrician, social services, finding her an apartment and clothes, helping her through the foster care placement for her daughter, and maintaining a supportive relationship during her psychiatric hospitalization. In this fashion, Ms. Pallone obtained first hand practical experience of ways in which to work with an abusive mother.

Dr. Lloyd Young, a psychiatrist who was chairman of the Task Force, had been to a workshop series in Denver. He worked with the abusive mother described above during her hospitalization, thereby becoming aware of Ms. Pallone's work with her; he asked Ms. Pallone if she would recruit additional volunteers who could also work with abusive parents. Dr. Young's only criterion for volunteer recruitment was that volunteers should be people who had themselves experienced good parenting.

Thus, in the spring of 1972, approximately 6 months after the Task Force was created and approximately 8 months after Ms. Pallone began working with the abusive mother, six volunteers were recruited through a local crisis intervention center and were trained by Dr. Young, Ms. Pallone and social services. When the plan to use the volunteers as lay therapists was first presented to the professionals on the Task Force, two of the Task Force members, both from the medical center, resigned but the rest of the Task Force backed the plan.

The six volunteers, four of whom remain with SCAN to this day, carried a total caseload of six cases: three from the mental health center referred by Dr. Young and three from social services. A few months after the initial recruitment, in August of 1972, social services agreed to a $20,000 budget which would pay the salary of a director and a secretary, as well as the expenses of twenty lay therapists. Because of

this initial contract with social services, SCAN was incorporated and many members of the Task Force served as the board of directors. Office space and phones were provided by the Arkansas State Hospital, which continues to house the program.

In their first half year of operation, the SCAN volunteers established their worth, particularly in the medical community. As the medical center and Children's Hospital became aware of several particularly difficult families to which SCAN provided intensive services, they became prime advocates for SCAN in its efforts to persuade social services to refer all abuse cases to SCAN. By January 1973, when SCAN called for a conference with social services, an agreement was reached whereby all cases of abuse would be referred directly to SCAN either by social services or by whatever other agencies became aware of cases.

Eight months later, in September of 1973, the SCAN program was expanded into three other counties. Volunteers were recruited, social services added the position of SCAN State coordinator, also providing SCAN with a WATS line to enable communication between the other counties and the central SCAN office in Little Rock. Within a couple of months of this expansion, the caseload had increased to such a point that it became necessary to hire an assistant director and a case evaluator who could conduct initial investigations.

One year ago, in May of 1974, SCAN, through social services, applied for and was awarded a demonstration grant from the Office of Child Development to develop the program in three additional counties. As the expansion of SCAN into other counties is the subject of a 3-year evaluation and as it is only a year old, the present case study is based only on the SCAN program in Pulaski County.

PROGRAM OBJECTIVES

The objectives of the SCAN program can be summarized as follows:

- To recruit, train, and provide a system of supervision and support for lay therapists who work with abusive parents
- To provide intensive supportive and therapeutic services to abusive families with children aged 12 and under
- To serve as advocates in the community for abusive families in a major effort to promote coordination of existing services and the development of new services
- To educate the public to changing attitudes toward abusers and to foster a climate in which abusive parents can refer themselves, even prior to an abuse incident
- To assist other communities in the development of a lay therapy program

PROGRAM AUSPICE

SCAN is a private nonprofit agency which receives funding under contract with the State Social Services Department. Its board of directors is comprised of nine community professionals, the SCAN director, and one lay therapist. The board assists in the development of policy, in helping SCAN in its functions vis-a-vis social services and the courts, and in the hiring of personnel. In addition, board members respond to requests for speakers by local civic groups and service providers.

PROGRAM COSTS AND SOURCES OF FUNDING

The budget for 1975-76 is $119,999. The entire cost of the program, with the exception of the 25 percent matching funds which are provided by various sources in the community, is paid for by Arkansas Social Services through Title IVA and IVB.

More than $92,000 of this budget is allocated to personnel and pays for the central staff of 10, as well as a part-time social worker and legal consultant. All of the staff works full time in the Pulaski County program, with the exception of the State director, who works 50 percent of her time on the Pulaski program and whose salary is accordingly paid 50 percent by Arkansas Social Services and 50 percent by the OCD grant.

Twenty-one thousand dollars of the budget is allocated to reimbursement of the volunteers who receive $50 a month for gas and expenses. The remainder of the budget is allocated to staff travel and to rent.

Almost all dollar resources go to direct or indirect services because virtually everyone on the staff, with the exception of two secretaries,

works with families, provides supervision to the lay therapists, and/or responds to requests for speaking engagements in the community.

FACILITIES

SCAN has a suite of several offices in one of the Arkansas State Hospital buildings. The SCAN location is extremely convenient as the mental health center is also on the grounds of the State Hospital and all of the services which SCAN uses are nearby.

Although nearly all client contacts are in the homes, clients do come to the central offices for group therapy or for Parents Anonymous meetings and staff does provide baby-sitting services at these times. Thus, one room is filled with bean bag chairs and every spare corner is stacked with children's toys.

COMMUNITY AND PARTICIPANT CHARACTERISTICS

Pulaski County is 765 square miles, with a population of 287,189.

The ethnic composition of Pulaski County is 79.4 percent caucasian and 20.6 percent non-caucasian. The median per capita income is $4,035. Children under the age of 18 represent 34.4 percent of the population.

Comprehensive data are being systematically compiled on the social-demographic characteristics of the client population as part of the OCD evaluation effort; currently these data are not yet available. It is estimated, however, that approximately 54 percent of the families served are caucasian and 46 percent are black. It is also estimated that approximately 40 percent of the client families receive AFDC.

Since the creation of SCAN, reporting has increased markedly. In 1967, the year in which the mandated reporting law was passed, there were 10 cases of abuse reported in the entire State of Arkansas. In 1973, the first year in which all abuse cases were reported to SCAN, there were 360 cases reported to the State registry. In 1972, the year immediately preceding SCAN's full-scale implementation, there were only 92 cases reported.

In the 14-month period from August 1972 to October 1973, SCAN provided services to 550 children in 216 families. Forty children were evaluated as not abused, 201 children were physically abused, 19 children were evaluated as "failure-to-thrive," 19 children were sexually abused, 14 children were emotionally abused, 166 were severely neglected, and 18 children were in danger of abuse as reported by parents themselves. In 15 families, the children were placed in foster care and in 3 of these families the children were returned.

THE STAFFING OF SCAN

The SCAN program in Pulaski County is staffed by a full-time staff of seven, plus a half-time State director, two part-time administrative

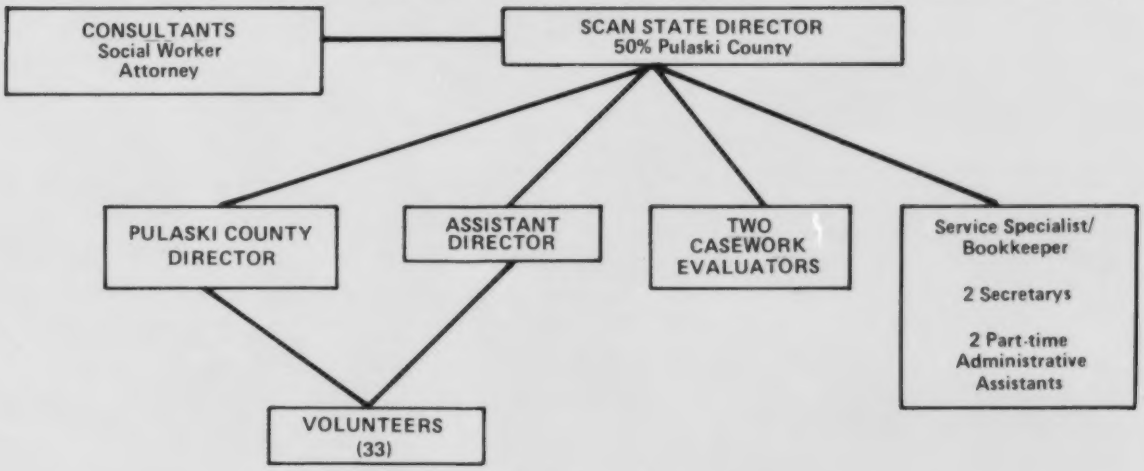


Figure 9. Staff organization

assistants, a part-time social work consultant, a part-time attorney, and 33 lay therapist volunteers.

The staff organization is depicted in figure 9.

State Director

The director, who spends 50 percent of her time in the Pulaski County program, supervises the evaluators in their intake work, supervises the director and assistant director in their work with the volunteers, and is involved in the treatment, training, case assignment, and supervision of volunteers. In addition, she coordinates with other agencies both on specific referrals and in an effort to expand the capability of the service delivery system vis-a-vis abusive families.

The director is the original founder of the Arkansas SCAN program. She has a BA in psychology and some graduate credits in psychology. She has received special training in the treatment of child abuse at the University of Colorado School of Medicine in Denver, Colorado.

Pulaski County Director and Assistant Director

These two individuals provide supervision to approximately 15 volunteers each; prepare all cases which are presented in court, which includes preparation of a summary, selection of witnesses and testimony, preparation of witnesses, preparation of orders and petitions to the court; coordinate with social services on families which have children in foster care and arrange for visits between parents and children; hold conferences with clients when it becomes necessary to remove a child or in some way to confront the client; and hold meetings with the prosecuting attorney and families which refuse to cooperate with SCAN in order to inform families that their choice lies between prosecution in court and treatment.

One of these individuals has been at SCAN for approximately 1½ years, the other for approximately 1 year. One individual, who has an MS in psychology, worked previously in the social service department of a nursing complex and as a psychologist with Head Start. The other individual has had several years of administrative experience in Arkansas Social Services and in the State health department as an evaluator of medical services vis-a-vis regulations and standards. This individual has an MA in special education.

Evaluators

At present there is only one evaluator; the other is part of the new contract which does not go into effect until July 1st. He responds to all referrals by making one or several visits to the home in order to assess whether or not there is a valid complaint and whether or not the family can best be served by SCAN. The individual who is currently in the position has been with SCAN for 4 months. His previous experience includes casework with Arkansas Social Services, coordinator for Arkansas Social Services on the OCD grant, and casework in the State Hospital School for Disturbed Adolescents. He has a BA degree in history and political science.

Service Specialist/Bookkeeper

This individual completes the Federal and State eligibility and day care forms, bookkeeping and billing to social services, emergency evaluations, carries four cases, and coordinates and provides transportation and babysitting services as a backup for Parents Anonymous meetings. She has had experience as a secretary and a social services caseworker. She has been with the program since its inception in 1972.

Consultants

The social work consultant (an MSW) participates in the two weekly staffing conferences and serves as the therapist for two therapy groups. This individual has been with SCAN in this capacity since January 1975.

The attorney is on the new contract starting July 1, 1975 and will represent SCAN in all court cases and provide legal consultation.

Volunteers

Three-day intensive training sessions for volunteers are held four times during the year. Many ofthe volunteers attend not only an initial training session but continue to attend the sessions for new volunteers, both because the training sessions have become more sophisticated over time and because the training takes on entirely new meaning for those who have had actual experience. In addition to an orientation to SCAN and sessions on the dynamics of child abuse, sessions are given by community professionals on identification, child development,

interviewing techniques, and transactional analysis. In addition, experienced lay therapists present some of their work with families and several members of Parents Anonymous make presentations in order to give new volunteers some firsthand experience with abusive parents.

At present there are 33 volunteers, whose experience ranges widely from previous experience in social services, broad experience in a variety of agencies, and business experience to no previous experience. Most of the volunteers have a BA degree. Volunteers are recruited by word of mouth and through newspaper articles. The majority of volunteers seem to have been recruited through their membership in local churches. Five of the volunteers are black, 28 are caucasian, three of them are men, the remainder are women. It is estimated that the average age of the volunteers is 35; many are considerably older and relatively few are less than 30. The great majority of the volunteers have had children of their own.

The initial screening of applicant volunteers is conducted by telephone, during which a major effort is directed toward making the volunteer understand the extensiveness of the responsibilities involved. Volunteers are told that they will be working with difficult families for 8-20 hours a week, that they must have their own transportation, and that they must be on call 7 days a week for 24 hours a day. Awareness of these expectations weeds out some volunteers; others are weeded out during the training session. Apparently this combination of screening and self-selection works well because only a very few volunteers have been asked to leave once they had actually started with families, and the dropout rate is less than 50 percent. Starting in September, the new plan is to give psychological tests to all volunteers for purposes of screening and research.

The volunteers are divided into four groups for purposes of supervision. Each group meets biweekly for a 2-hour staffing. At the staffing each volunteer in the group gives a brief updated summary on each of her cases. The typical volunteer carries three cases and sees each of her families from one to three times a week. Following the review of each case, other volunteers, the staff, and the social work consultant offer suggestions, ask for further clarification, or provide encouragement and approval. Complex situations which require more careful and detailed planning are identified and are dealt with in individual supervision on an "as needed" and "per request" basis.

Volunteers are encouraged to phone their supervisor or another staff member, or drop in for consultation, as often and whenever they wish. It is assumed that they are responsible individuals who will seek help and/or information whenever needed. At times, the supervisor will join the lay therapist for a visit to the family in an effort to better understand the family and to teach interviewing style and techniques to the lay therapist.

Staff and volunteers provide each other with a mutual support system which is very much in evidence.

DIRECT SERVICES

IDENTIFICATION

When possible, all initial calls are handled by the administrative assistant. Information obtained during the call is typed up and given to the evaluator for followup action. Approximately 70 cases are screened each month. Depending upon the referral source, the evaluator makes his initial visit to the home, the hospital, or the school. In an emergency, the case is evaluated immediately. The evaluator wears a pager and can be contacted at all times.

In 1974, SCAN received 612 referrals among which 556 intakes were conducted. The remaining cases represented clear cases of neglect and were referred to social services. Following initial investigation, less than 50 percent of the cases are assigned a SCAN worker. Some cases require referral to other agencies, a few cases are unconfirmed, and some require only immediate crisis intervention.

In cases where there is evidence of abuse in the hospital workup or when there are clear marks on the child's face or body, the evaluator tells the family that he is from SCAN and that SCAN wants to work with the family in order to help them. Those families who refuse help are told that they can be prosecuted; if necessary a subpoena is issued and the family then meets with the district attorney and with SCAN so that they may clearly understand their options. If the family still refuses to work with SCAN, a court order can be obtained for the child to be seen at the hospital and in some cases foster care is recommended.

In cases where there is no physical evidence of abuse, but the mother does seem isolated, has unrealistic expectations, and talks about the child as if she/he is bad, the evaluator indicates his view that there are problems and offers the services of SCAN. If she refuses SCAN assistance, the SCAN number is left and a list of possible services, e.g., day care, child study center diagnostic services are mentioned. The hope is that the next time the mother becomes exasperated she will call SCAN, at least in order to find out about eligibility for a concrete service.

Every effort is made to get families to accept services. In addition to the efforts of the evaluator and the legal sanctions described, SCAN staff makes initial visits, as do members of Parents Anonymous. Similarly, lay therapists sometimes spend months working so that a family will accept their offer of a relationship and of assistance.

In addition to cases referred by hospitals where there is hard evidence of abuse, cases seen by the evaluator where there are marks and bruises on the child, cases in which the dynamics of abuse are present but without any marks, and cases of sexual abuse, SCAN also deals with failure-to-thrive cases and with self-referred clients who call in asking for help.

Cases which are identified as neglect are referred to social services, cases of children over 12 years of age are referred to the Criminal Justice Project. SCAN deals with all cases of abuse in families with children 0-12 years of age.

A report on all intakes is sent to Arkansas Social Services and to the county attorney's office. This information becomes the basis of the report to the State registry.

CASE MANAGEMENT

Case management, which includes the coordination of all resources on behalf of a family, is the responsibility of the lay therapist. Information and backup are of course available from the SCAN staff. Lay therapists help clients to secure food stamps, welfare benefits, appropriate housing and clothing, day care, special education, medical diagnostic and treatment services, and professional counseling and treatment. Until such time as the client can negotiate these systems on her own, the therapists accompany clients on visits to resources, obtaining information and providing feedback to the clients.

In most instances, available community resources are used; goods and services are not provided directly by the therapist. For instance, therapists are encouraged to obtain donated food and clothing through their church groups rather than to provide clients with food and clothing from their own homes. Ultimately, however, such decisions are left to the therapist.

Lay therapists provide coordination with social services for families with children in foster care. In most cases an effort is made to have weekly visits; the lay therapists have responsibility for bringing the children to the home, for being present for at least part of the visit, and for returning the children to the foster home.

SCAN has 24-hour answering service and pagers are worn by three staff members so that someone is available to the families and to the community at all times in case of crisis.

TREATMENT

SCAN offers three kinds of therapy: individual therapy which is the domain of the lay therapist, group therapy in weekly sessions which are run by the social work consultant, and Parents Anonymous, for which SCAN acts as a sponsor.

The underlying SCAN treatment philosophy, formulated by Dr. Lois Malkenes of the Arkansas School of Nursing and by Sharon Pallone, the SCAN director, is at the core of the work done by the lay therapists. Essentially, the treatment is conceptualized as a three-stage process in which the first stage is one of dependency, the second is one of interdependency, and the third is one of independence.

The task of the lay therapist during the dependency stage is to help the client establish a relationship of trust in which the therapist is seen as a nurturant parent. The emphasis is on reparenting and promoting a positive dependent relationship. Lay therapists give their phone numbers to clients and make it clear that they are available to provide help 24 hours a day. During this phase, the lay therapists seek to meet concrete needs and to connect the client with services and resources. They provide clients with information and serve as a source of transportation to the grocery store, to medical appointments, and to other services. Concrete needs in regard to housing, jobs, and day care are met through direct intervention. It is felt that by experiencing a relationship of trust

in which the emphasis is on acceptance of the parent and on meeting the parent's needs, the parent's self-concept and isolation will change. Reparenting involves acting in a loving but firm manner, setting limits, being available, and giving information. In the dependency stage the parent is described as adaptive, in the sense that she tends to be compliant and to do all of the things she is supposed to do.

The SCAN view of treatment is that the teaching of alternatives to abuse cannot be effective until the dependency needs are met. The staff feels that most other treatment agencies fail with abusive parents because they overlook the dependency stage and start by trying to teach parents about their unrealistic expectations and about parenting alternatives. In the SCAN conceptualization, none of these alternatives can be heard until the dependency needs are met and a relationship is established. Thus, in this phase the therapist avoids suggestions, there are few expectations and few goals are set. The only expectation is that the abuse of the child must cease.

At some point before the second stage of interdependency most parents are described as going through an identity crisis because they cannot recognize themselves in their present behavior. Whereas all their lives they and others saw them negatively, now they are liked and seen positively. The shift from a negative to a positive image leads to an agitated questioning about self-identity and to a reappearance of negative behavior. Often the reappearance of negative behavior is precipitated by the fact that the compliance of the client in the first stage makes everyone think that problems have been stabilized and the therapist begins to pull back in terms of frequency of contact and extent of support. The client is likely to set herself up for failure because of the identity crisis, because of anxiety that she cannot make it on her own, and in order to prevent the loss of the therapist. Also, the child is often unable to trust the new forms of discipline and the firm limit setting and behaves in a particularly testing manner. At this point, the therapist once again increases the support but begins to focus on the client's capacity for interdependency.

In the second stage, the parent has begun to accept herself and is taught that self-nurturance is not only acceptable, but also important. The parent is taught discipline alternatives to abuse and receives positive reinforcement when they are used. Parents are encouraged to rely on problem-solving rather than impulse-ridden behavior.

When independence is achieved, the family is considered to have been stabilized; from this point on, contact may be only every few months, or around holidays.

In most cases, the therapeutic relationship is primarily with the mother. Fathers are less apt to be home during the day when most visits are made, and are generally less accessible. In some cases, the lay therapist does work with the couple; however, the assumption is that if one partner receives help, the other partner will also begin to change. While the lay therapists receive considerable training in one-to-one counseling, there is relatively little emphasis on marital counseling or on couple therapy.

Therapy tends to be long term, except in cases of crisis intervention or in preventive cases where the mother is self-referred and concerned about what she may do. Relationships with many families have continued over the 3-year life of the program, although approximately 85 out of a total of 236 families assigned to SCAN workers since program inception are considered stabilized. There is no pressure to terminate the relationship until both client and therapist feel that the client's needs have been met and that she can function independently. Criteria for improvement include ability to get their own needs met through use of community services, realistic and appropriate expectations for the children, ability to recognize and avoid situations which represent "set-ups" for frustration and failure, ability to provide children with positive reinforcement for appropriate behavior, and ability to think of and act on alternative solutions from a rational problem-solving position.

Lay Therapy

The cases that follow illustrate the intensity of the relationships established with clients, the depth of therapist commitment, and the processes of change over time.

Sylvia

Sylvia has been in treatment with SCAN for 1½ years. She is divorced, has two children, a girl age 7 and a boy age 6, and was self-referred. Prior to her contact with SCAN, she had been seeing a psychiatrist and telling him about her concern that she would harm her children. She

brought this issue up several times and each time her psychiatrist assured her that she would not abuse the children. Unable to get the psychiatrist to take her concern seriously, she heard about Parents Anonymous (PA) and went to a meeting. PA referred her to SCAN. Throughout her relationship with SCAN she has continued to work with her psychiatrist and with PA.

On the first visit, the lay therapist went out to Sylvia's home to introduce herself and within 15 minutes Sylvia poured out her whole story and all the abuse incidents in which she had been involved. She also told the therapist about her father's death in the previous year and the fact that her exhusband would not allow her to discuss it. She talked about her own suicide attempts and previous hospitalizations.

The therapist returned within 3 days and Sylvia described how in the interim she had lost her temper, had told the children to go to their room, and had proceeded to demolish all the furniture and dishes in her rage. However, she had not harmed the children; her physical abuse of them is reported to have stopped at that point.

The focus of the early contact, which was approximately three times weekly, was on conversation and on providing a friendly listener. The therapist responded enthusiastically to insights which Sylvia verbalized, when she thought they made sense, but made no interpretations of her own. Sylvia was hospitalized several times in the State hospital; the therapist continued to provide support and friendship during these periods. When Sylvia met a young man who told her about his girlfriend in another State, the therapist talked about how she was setting herself up to be hurt, but let her know that as long as she knew about the setup and still wanted to see him that was her choice. When the therapist visited Sylvia in the hospital, she responded to Sylvia's statements that she only had to stay alive for the sake of the children, by letting her know that she needed to stay alive for herself, and that she did not want to hear any false sentiments. In one of Sylvia's hospitalizations for a persistent physical problem, her therapist fought with her and with her doctor to keep her out of the State hospital, feeling that such a hospitalization would only represent another defeat.

Throughout the relationship, the therapist has provided support for Sylvia's positive efforts and has expressed her warmth and liking for Sylvia as a person. When Sylvia's daughter told Sylvia how much she liked her because she doesn't hit or hurt her anymore, Sylvia called the therapist to share this with her and her therapist immediately came to visit and brought her a flower so that they could share Sylvia's excitement and pleasure.

During her most recent stay in the State hospital, Sylvia met a fellow patient and married him. Since the marriage he has begun abusing the children and the therapist helped Sylvia to get a restraining order to prevent him from coming to the house. It has become apparent that Sylvia seeks out crisis situations because these energize her and she thrives on them. Recently, the therapist has begun letting her know that she wants to talk to Sylvia when she's feeling good and not when she's on a "crisis high." Sylvia has been told that the therapist is not going to feed her crisis highs by responding to them.

The husband, who has already been hospitalized three times since the marriage, has returned home and has begun to reach out to the therapist for contact. It is anticipated that the therapist will begin working with both of them in an effort to stabilize their marriage. In the meantime, it is reported that Sylvia does take very good care of the children and very much enjoys taking them to the zoo, playing with them, and taking care of them.

Danielle

Danielle was referred to SCAN after she attempted to suffocate her infant son. Danielle and her husband, who was in the Air Force, had multiple financial and personal problems. They had met while they were both in a mental hospital. At the time of the marriage Danielle was 16 years old; soon after the marriage she had her baby. At the time of the abuse, Danielle's husband had been rehospitalized. Having no one to whom she could turn, she was flown by the Red Cross to her in-laws in Little Rock, whom she had never met. After 2 weeks with her in-laws, she decided to kill herself and the baby since she couldn't think of anyone with whom she could leave the baby. The in-laws intervened in time and the baby was hospitalized, while Danielle was placed in the State hospital. Following his hospitalization, the baby was placed in a foster home.

As a means to initiating contact, the SCAN therapist first came to Danielle while she was hospitalized. Because no one else came to visit Danielle, the therapist came every day. Gradually, she began to take Danielle out of the hospital for walks and for short excursions. They spent a great deal of time just walking and talking. It took Danielle a long time before she could trust her therapist enough to talk to her, but the therapist was in no hurry and did not push.

When Danielle was discharged from the hospital the therapist helped her find a place to live. When this apartment did not work out, and while in the process of waiting for admission to the hospital live-in rehabilitation program, the therapist and Danielle decided that Danielle should live with the therapist temporarily. The SCAN staff advised against this, but also let the therapist know that if she went into it with her eyes open the decision was her own.

Danielle did move in with the therapist and her family for a week and the experience turned out to be extremely positive. Danielle and the therapist cooked and did dishes together and Danielle had the opportunity to do many of the things that a teenager would ordinarily do with her mother. The process of reparenting is most poignantly illustrated by a moment in which Danielle asked her therapist to brush her hair after she had washed it and then began to cry as the therapist began brushing, remembering that her own mother had invariably become impatient when she was brushing her hair and hit her around the head with the brush.

After approximately 1 week, Danielle went to live at the rehabilitation center, but eventually moved back with her husband. Following her return to him, she took an overdose of pills and nearly succeeded in killing herself. At that point, the therapist asked her to make a written contract with her that she would never again attempt suicide without calling the therapist first. Danielle has stuck to her end of the bargain and has only once had to use her therapist in this way. On this occasion the therapist came over immediately and stayed with her until 2:00 a.m. comforting her and talking about alternative solutions.

After Danielle returned to her husband, the therapist tried to work with both of them, but he tended to see her as Danielle's friend and ally, aligned against him. Recently, he has begun to relate more to the therapist and is beginning to respond to her efforts to help him see himself as an effective and worthwhile person. He has begun to invite her to visit them when he is home and makes a point of joining their conversation.

As a couple, Danielle and her husband have begun to do more things together. They have a dog and take him for walks together, they have begun to cook together, and recently they bought a game of Monopoly and have begun to play together. The baby comes home every Friday and stays until Monday. He is reported to be a healthy, developmentally sound baby and the weekend visits have gone so well that an extended one-month visit is being planned. Danielle is perceived as a good mother who takes excellent care of the baby and the extended visit is expected to go well unless the marital problems surface and interfere. However, there seems to be utmost confidence that if Danielle experiences any tension or anxiety, she will call and ask for help. It is expected that the routine of taking care of a child will be difficult for them and arrangements have been made for the baby to be in day care. It is felt that the month will give Danielle and her husband a realistic opportunity to assess whether or not they want responsibility for their child. If not, they will be encouraged to put the baby up for adoption.

Annebelle

Annebelle, her husband, and three children ages 7, 5, and 4 were referred to SCAN nearly 2 years ago by the neighbors and the school. The school reported multiple bruises and abrasions on the oldest child and the neighbors reported that she had been tied to a tree by her hands and feet for an entire day.

When the SCAN worker first went to the house, she found a dirty log cabin without gas, electricity, or plumbing, and with broken window panes. In the yard there were 30 dogs and the 3 children who brought the therapist into the house. Annebelle was busy peeling potatoes and the therapist simply told her her name and that she had come to see if she could help. The therapist commented on Annebelle's potatoes and asked her if she had purchased them with food stamps. When Annebelle indicated that she didn't know what food stamps were and that she had no means of transportation, the therapist asked her if she would like her to come by the next day to take her to get food stamps. The next day the therapist took Annebelle and the

children to get food stamps and waited in line with them for 7 hours. Finally, the food stamps were acquired and the therapist took Annebelle to the grocery store. Efforts to help Annebelle to buy vegetables and other nutritious foods were to no avail and the family continues to live primarily on potatoes and beans.

The following week the therapist went to talk to the oldest child's teacher and was told that the child simply could not function in a regular classroom. At that point, the therapist made arrangements for the child to be in a special school. The mother and the children were evaluated at the mental health center and again the therapist took the family and waited with them until they were seen. At Christmas, the therapist persuaded the Santa Claus at her local church to stop in and see Annebelle and her family.

The Christmas activities, which included taking the family to a party and introducing the therapist's husband to the family, served as a turning point. After this it became clear that Annebelle perceived her therapist as a friend and turned to her for advice and assistance. After 6 months of regular visits and concrete assistance, a relationship of trust had been established and the therapist felt that it was possible to discuss the original referral.

At this point, the therapist began to talk to Annebelle about the original referral and about more recent incidents reported by the school. Apparently, in the most recent episode, the eldest daughter, Julie, had run away and Annebelle had given her a beating. At this point, the therapist told Annebelle very firmly that she had to stop beating Julie and that they would have to figure out another way. The therapist told Annebelle that if she continued to beat the children, she and her husband and the therapist would all get in trouble and if the therapist got into trouble she would no longer be able to come for visits, the children would be taken away, and it would be hard to get them back. Annebelle agreed and the abuse stopped.

When it came time for the second child to be in school, that child also was placed in the special education school. The third child will start school in the fall of 1975, which is especially important as the food in the house continues to be very unnutritious.

The therapist arranged for Annebelle to use a contraceptive device and despite her husband's refusal to allow any contraception, she has gone with the therapist and has been able to protect herself. At this point, Annebelle calls the therapist whenever she has a problem and is extremely diligent about seeing to it that the children go to school. She has found other ways to discipline the children and although she still hits them, she no longer beats them.

Initially, Julie had an extremely difficult time in school and continues to dress and behave in a manner which is considered more appropriate for a teenager than for a 9-year-old child. The therapist worked out a contract with her whereby she was given 50 cents for every A and this helped her to be more motivated and also served as a way of giving her some pocket money, which seemed important as the school reported that she was stealing.

The therapist sees Julie approximately once a month when they go shopping for clothes and keep medical appointments together. Julie calls the therapist on the phone when she needs help, but it is recognized that Julie needs someone to work with her more frequently and intensely.

Better housing for the family was found, the abuse has stopped, and although the family is still extremely needy and the environment does not promote the positive development of the children, the situation has stabilized. The strong relationships between Annebelle and her therapist, and between SCAN and the children's school ensure that SCAN is kept informed about whatever affects the welfare of the children.

John and Jane

John and Jane were referred by juvenile court in the fall of 1973. The court had been called by a neighbor who reported that there were a 4-year-old and a baby who were frequently beaten and thrown against the wall; the neighbor expressed concern because she had not heard the 4-year-old for an entire day. The evaluator went out to the home but was unable to gain entré. Later in the day, the SCAN director went out and was met at the front door by Jane and the 4-year-old. The SCAN director introduced herself and explained that a report of child abuse had been made to SCAN. The child had multiple bruises on her face, but the request to enter the house was denied and Jane also refused to come out. The director seated herself on the front steps, stating that she would wait. Shortly thereafter, Jane came out. They had a brief conversation in which Jane admitted beating the 4-year-old. Jane was told that SCAN wanted to

work with the family and that in fact they would have to work together because the law did not allow the beating of children. She also told Jane about the PA meeting that evening and urged that she and John attend a meeting.

John and Jane came to SCAN that evening and John declared that he had been on his own since the age of 8, had been in prison at the age of 15, and had no intention of receiving help from anyone. He also announced that he was not going to the PA meeting. He was told that SCAN would respect his choice but that SCAN also had a choice: to refer him to the court. At this point, he decided to capitulate and they did attend the meeting.

At the meeting, John acted in an extremely hostile and provocative manner. Although children are not allowed at PA, the children did come and sat through the entire meeting without ever moving or making a sound. The baby, who was 13 months old, looked like a 7-month-old infant with a fixed gaze and a totally compliant manner.

The next morning, John and Jane came and asked for money for food. Their needs were met, but once again SCAN expressed concern for the children and asked that they be seen at Children's Hospital. They were told that staff would be glad to accompany them, but that there was no choice about going. When the physician saw the children he decided to hospitalize them, which infuriated John. He was reassured that he was a good parent and that it was expected that he would allow the children to stay in the hospital because of their need for medical attention.

The baby was diagnosed as having several old and new fractures and a badly scarred palate from repeated force feedings. Following a conference with the juvenile judge, it was decided that if the parents would accept day care, SCAN, and psychological evaluation, the children could go home. In the middle of this conference, the attending physician discharged the children and when John heard this he took the children and bolted. At that point, SCAN called the juvenile referee and the sheriff's office and four sheriffs went to the house to pick up the children, who were placed in foster care.

On the very same night the children were forcibly removed, John had an attack of appendicitis which resulted in his hospitalization. This enabled SCAN to visit him and show their concern for him. This was a turning point because after that he started coming to PA meetings and keeping in touch with his SCAN worker. After 3 weeks, they started having supervised visits with the children which went well until the eldest appeared with a hair cut and called the foster parents "mommy" and "daddy." Although John reacted violently and threatened everyone with his gun and his lawyer, the visits continued and they started to relate better to the children during the visits.

During this whole period of time they were seen intensively both by the SCAN worker and by a social worker at the mental health center. The two therapists were in frequent coordination so that treatment goals, techniques, and events could be shared. SCAN found the couple new housing and helped John to get a job. PA worked with him in helping him to find alternatives for his explosive temper, and the social worker addressed herself to their communication as a couple. Jane, who was symbiotically attached to John, was encouraged to ventilate, talk, and achieve at least a minimum of a separate identity.

Within 3 months of the initial contact the children were returned to their parents. The conditions of the return which were carefully planned and set forth by the judge were: continuation with SCAN, the mental health center, day care, and prohibition against leaving the State. In addition, the judge insisted that they be married and since John was under age, their SCAN worker became his legal guardian. Within about 2 months of the return of the children, things started to deteriorate. The children did not regularly attend day care, John and Jane did not regularly see their SCAN or their mental health worker, the children were sickly, and Jane was 8 months pregnant. The younger child was reported to have run out in front of a truck and John beat him severely with a belt. Following a conference with the judge, it was decided to take the children back into protective custody. This time they were able to discuss the removal of their children rationally and calmly with the SCAN worker.

The new baby was born and the three of them seemed to be doing very well. At about 6 weeks of age, John was holding the baby and their dog jumped up and she started to fall. As he grabbed her arm it broke and he panicked. He called SCAN and told them he was taking the baby to the hospital and to please meet him there. The doctors felt that the break was not due to a

twisting and that it could well be an accident; the baby was sent home. She has continued to grow and develop for the past 11 months and John is extremely proud of her.

After 9 months in foster care, the two older children were returned. The parents continue to be unreliable about day care and they continue to move frequently, but there have been no further incidents of abuse. John and Jane continue to be in touch with SCAN and sporadically participate in PA. John brings childrearing problems up, e.g., the eldest started wetting her bed at night and he told the PA group that he had thought of rewarding her for staying dry instead of punishing her for wetting, because he wanted to set her up as a winner and not as a loser. John no longer carries a gun and has been very helpful to the SCAN staff in terms of minor house repairs and other odd jobs. As a couple they have gone to the homes of other difficult and hostile couples to encourage them to join PA. At this point, they turn to SCAN when they need help and have publicly spoken at PA panels of their certain knowledge that SCAN cares about them and will do anything to help.

Group Therapy

There are two groups with approximately eight members each. Each group meets once a week with the part-time social worker. The group is composed of intrinsically motivated people: those who do not want to come or for whom treatment is court-ordered are not accepted. Potential clients are told that the group is for people who want to work on something that is making them uncomfortable and that if they join they will not be able to miss more than two sessions in a row without calling. Although men are welcome, the membership tends to be almost totally female.

The basic therapeutic approach is transactional analysis in which the therapist does a great deal of teaching and modeling. The therapist describes her own experiences as a parent and stresses problem-solving behavior. When parents report some inappropriate behavior, they are expected to address themselves to the question "what else could you have done?" In the beginning, new members are asked how they want to be different and what their goals are. Each person has a contract with the therapist; no one is allowed to merely recite, report, or ventilate. The contract spells out a specific change which is unique to the person in treatment, rather than to someone else.

Sessions generally begin with the therapist asking "who wants something?" Once a person identifies a problem, the therapist begins to illustrate to them the nature of the conflict which is being expressed. While the therapist works with an individual, the rest of the group watches and hopefully learns but is not encouraged to join in. However, in certain instances, e.g., when someone is afraid of trusting or afraid of taking a risk, the therapist structures stroking exercises with input from the group. Essentially, individual therapy takes place in the group but the group has certain advantages in that it is seen as an energizing factor and as a protection against the tendency to become involved in game playing. In other words, if a client is not really working, the therapist can move on to someone else. In addition, group members are encouraged to socialize outside of the group and do tend to become friends and develop a support system for each other.

With an emphasis on rational problem-solving behavior, aggressive behavior is simply ignored. Faced with an irrationally angry client, the therapist might well explain to the person that it is clear that she is not in a good place and that she will talk to her later when she is ready to work. Clients receive strokes, both physical and mental, for problem-solving behavior but never for ventilation or impulse-ridden behavior.

The following case is intended to illustrate the process and techniques of the group therapy.

Charlotte

When Charlotte first started in the group, her two children were living with her mother and she had referred herself because of her fear that she would harm them.

When she first came to the group she learned that she had a "don't grow up" injunction from her mother so that while she had gotten married and had children like an adult, she really was still acting the role of irresponsible child. Her first task in growing up was to learn to like herself. This was accomplished using homework assignments assigned by the therapist. She was asked to look in the mirror as long as she could but to turn away when she began to feel critical. The therapist does not check on whether homework assignments have

been done, but assumes that if they are meaningful to the individual they will be done. If an individual reports on his assignment in group, the therapist gives strokes for the behavior.

Once Charlotte began to like herself, she began to feel sufficiently worthwhile to make an effort in her own behalf. Thus, she began to keep her house clean and recently has made a contract to lose weight. As part of her growing sense of responsibility, she has gotten and held a job, sees her children more often, and is more responsive with them. Currently, she listens to them, reads to them, and is able to let them know that sometimes when she is upset it has nothing to do with them.

She has begun to separate herself from her mother, from her boss, and from the children. She understands that other individuals cannot make her angry, but that it is she who makes herself angry. As part of her new sense of responsibility, she comes to work on time and no longer relies on her mother to wake her up.

Parents Anonymous

Parents Anonymous (PA) meets once a week for 2 hours and has approximately 30 members. Group size for any given meeting ranges from 6-30. The meetings are presided over by the elected PA chairman and attended by the PA elected sponsor. The Little Rock PA sponsor is the SCAN director. The role of the sponsor is not to act as group therapist, but to provide information.

PA tends to do a great deal of confronting and is very direct; it is felt to be effective for parents who do not deny their abuse. SCAN encourages all parents to attend PA. SCAN offers PA, but does not demand it; occasionally the court orders it.

PA has meetings in which people talk and tell about their experiences as abusive parents. Other meetings have invited speakers to make presentations to the group on such topics as transactional analysis, child development, behavior modification, and human sexuality.

Some of the group members have been with PA since it began a little over 2 years ago. These members give the group stability and serve on a panel of parents which participate in a variety of presentations to lay and professional audiences. It is felt that a mix of old and new members is optimal to give the group stability, as well as a sense of continuing purpose and mission which derives from an effort to help newer members.

This particular group has progressed from being extremely competitive and hostile, in which members trusted no one and brought guns and knives to meetings, to a much higher level of socialization and group process. Group members are supportive of one another, help each other to recognize setups, and are intolerant of any abuse.

THE SERVICE DELIVERY SYSTEM

The 1967 Arkansas State Law mandates the reporting of all cases of abuse to the State social services agency. Thus, the agency legally responsible for all cases of abuse is social services. Since social services contracts with SCAN, there is a very close working relationship between the two agencies. Caseworkers in social services have caseloads of approximately 80 families each. Pulaski County Social Services and SCAN represent two parts of a four-part system. The third aspect of the system is the Child Protection Committee, which serves Arkansas Medical Center and Children's Hospital and serves as a support system to all agencies handling abuse cases. The Committee includes representatives from medicine, social services, nursing, pathology, and radiology, as well as from the prosecuting attorney's office, the Department of Social Services, and SCAN. This group meets weekly to review cases and coordinate planning among the various agencies represented. The fourth aspect of the system is the Arkansas Council for Child Protection, whose primary role is one of education.

The law enforcement agencies and systems in the community work very closely and effectively with SCAN. The prosecuting attorney, who was elected in 1973, avoids bringing criminal charges against any abuser except in cases of murder. Thus, abusive parents are not prosecuted and are referred to juvenile court only if they refuse to cooperate with SCAN. The prosecuting attorney's office works with SCAN to prepare all cases for court in order to ensure that the case is as well prepared and presented as possible. The juvenile court judge has a close working relationship with SCAN and uses her court authority to assist in the attainment of therapeutic goals. The Criminal

Justice Project, which has responsibility for all abuse cases over the age of 12, also works very closely with SCAN. Because some families have children in the age group of each agency, and because staff of the Criminal Justice Project has particular legal expertise, there is considerable coordination between these two agencies.

The mental health center works with relatively few abusive families because it is felt that SCAN's aggressive outreach, frequent contact, and 24-hour on-call availability represent the most effective treatment. However, in cases which are shared jointly, there is very close coordination; the social worker who treats most of the abuse cases at the mental health center at times includes the lay therapist in her sessions with a client.

Despite the fact that SCAN is staffed by lay therapists, the program seems to be universally accepted by professionals in other agencies. The seriousness and commitment of the volunteers, their level of knowledge as they discuss their clients with various professionals, the lack of turnover in volunteers, and the absence of any serious reinjury to any child within a family with which SCAN has worked, have convinced community professionals of the effectiveness of the program. Community professionals participate in the training of the volunteers and hence are aware of the level of their knowledge. While there may initially have been doubts within the professional community, at this point the medical, social work, and legal professionals seem entirely convinced of SCAN's effectiveness and work with them in a close collaborative relationship. The 24-hour availability of the volunteers and of the SCAN staff has also impressed professionals. Several people in the medical community expressed the opinion that physicians are far more willing to report abuse now that there is an effective treatment resource available.

COMMUNITY EDUCATION AND TRAINING SERVICE PROVIDERS

The SCAN staff, lay therapists, and panel of PA parents participate in speaking engagements throughout the county and the State. In addition, the SCAN director has spoken outside of the State, as many communities have expressed an interest in developing a SCAN volunteer program.

Through SCAN efforts, various individuals have spoken to church groups, high school and college classes, students at the school of nursing, voluntary associations, local hospitals, and various civic groups.

Several community professionals reported that SCAN has made a considerable contribution both to public awareness of the problem and to a community tolerance of help rather than prosecution for abusers through their radio and television appearances.

It is reported that approximately three requests a week for public speaking engagements come to SCAN from the community and efforts are made to honor all of these.

SUMMARY OF KEY FEATURES

Unlike other programs in which volunteers or parent aides may feel like second-class citizens in an agency that belongs to someone else, SCAN is their own organization and provides an ongoing system of inservice training and support. The maintenance of a separate volunteer organization as an entity, rather than as an attachment to some other organization, gives the volunteers a sense of identity and status which appears to be of great importance.

SCAN has certainly demonstrated that it is possible to recruit and maintain the sustained interest of volunteers who can be trained to work with very difficult and demanding families. The majority of volunteers are from a different socioeconomic group than the families with which they work, and yet have shown themselves able to develop close relationships with the families. Volunteers speak of the meaning of the SCAN experience in their own lives and it is clear that they perceive it as a remarkable opportunity for their own growth and development. While the volunteers are called lay therapists it should be clear that the vast majority of workers in protective services have no more than a BA degree and also have less intensive supervision and ongoing inservice training than do the SCAN volunteers. The movement away from professionalism has also allowed SCAN to encourage, support, and work with Parents Anonymous.

As is the case in any group of professionals, there is considerable variability in the clarity of conceptualization and the range of responses available to the SCAN therapists. It is also apparent that the best of them is likely to be as

effective as an experienced and well-trained professional. Even the least effective among them is likely to do better than the overworked social service staff with caseloads of 30 and more, if only because of the intensity of contact with clients. The intensive services which SCAN is able to provide, which include contacts up to five times a week, the lack of sense of urgency about pushing families to set goals and accomplish specific tasks, and the willingness to allow a relatively long period of dependency in the service of the development of a relationship of trust are only possible with caseloads which range from two to four families.

Unlike most programs in which lay therapists or parent aides work with only one family at a time, most of the SCAN lay therapists work with at least three families. It is possible that their enormous commitment to the program and to their work is in part a function not only of their identification with their own agency and of ongoing supervision, but also of this larger caseload. It may well be that this larger caseload helps to make the work more salient to the life of the volunteer in that it provides a "critical mass" of experience.

The SCAN program also provides an important model of a purchase of service agreement between the public social services agency and a private nonprofit agency. Certainly, it represents one way of allowing protective services to upgrade the services for which it is responsible.

Chapter III — Public Social Service Agency-Based Programs

INTRODUCTION

Both of the programs presented in this section are programs developed and operated by mandated public social service agencies. Each illustrates what can be done within a public agency with adequate funding which permits manageable caseloads and time for supervision and staff development. Whereas most protective service agencies visited have caseloads of 60 to 80 and at best see clients every few months, these two programs tend to have caseloads which are not larger than 25 and to maintain contact with clients weekly or biweekly.

The two programs represent opposites in their approaches to working with other agencies and the development of new resources. The Hennepin County program seeks to develop resources and expertise within the department and maintains not only responsibility but also authority for abusive and neglectful families. The Lehigh-Northampton program illustrates a collaborative effort between child welfare, the mental health agency, and a child development program. In the Lehigh-Northampton program, the three agencies share case responsibility; staff from mental health and child welfare act as co-therapists in group settings and participate regularly in joint staffings.

Both programs have a specialized abuse unit within protective services, although the Hennepin County program makes less of a distinction between abuse and neglect cases than does the Lehigh-Northampton program. Both emphasize the maintenance of records, case review, and service statistics as tools for more effective program growth and development. Because of its collaboration with professionals in other agencies, the Lehigh-Northampton program offers a wider range of therapeutic services including, in addition to individual counseling, a highly developed group therapy approach and a family therapy approach.

Hennepin County Welfare Department, Minneapolis, Minnesota

by Monica Holmes, Ph.D., and Dorie Greenspan

Director of Protective Services: Philip Dolinger, MSW

START-UP

The Hennepin County Welfare Department has been responsible for child protective services since 1945, when the staff consisted of a supervisor and three staff social workers. Following passage of Minnesota's Mandatory Reporting Law in 1965, the rate of referrals per year increased; while the program has grown since that time, there have been no milestones or dramatic changes. Reporting has increased with accompanying increases in staff until 1972, when it reached its present size: four field units, each with a supervisor and either 8 or 9 workers, and one assessment unit with a supervisor and 6 staff.

PROGRAM OBJECTIVES

The objectives of Protective Services can be summarized as follows.

- to assume responsibility for abused and neglected children when their parents are unable to take that responsibility
- to assist families so that they can remain together through casework and through coordination of other available resources
- to provide information to the public and to other service providers about child abuse and neglect

PROGRAM AUSPICE

Administratively, Hennepin County Protective Services is within the Family Service Division of the Welfare Department. Within the Family Service Division there are two branches: Family Counseling, which maintains 19 units for provision of services to voluntary clients, and Protective Services, which provides service to involuntary clients.

In addition to the Family Service Division, the Welfare Department has a Community Action Division, a Facilitation Services Division, a Work and Training Division, and an Adult Services Division. Many services are available to Protective Services through its parent organization: e.g., group work services, court services, household management services.

PROGRAM COSTS AND SOURCES OF FUNDING

The annual budget is approximately $1,397,000, allocated as shown in figure 10.

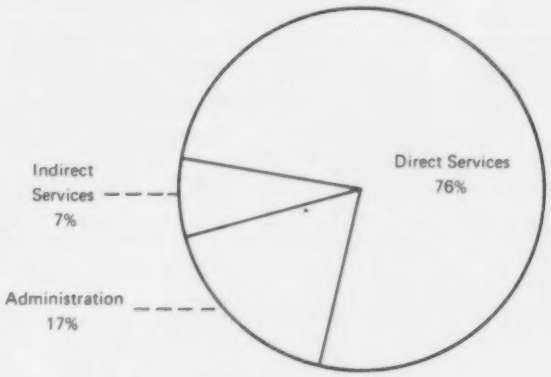


Figure 10. Budget allocation

Sources of funding are presented in table 2.

Table 2. Sources of funding

Federal	*Percent of funding*
HEW; SRS	59
State	
Department of Public Welfare	18
County	
Welfare Department	23
Total	100 percent

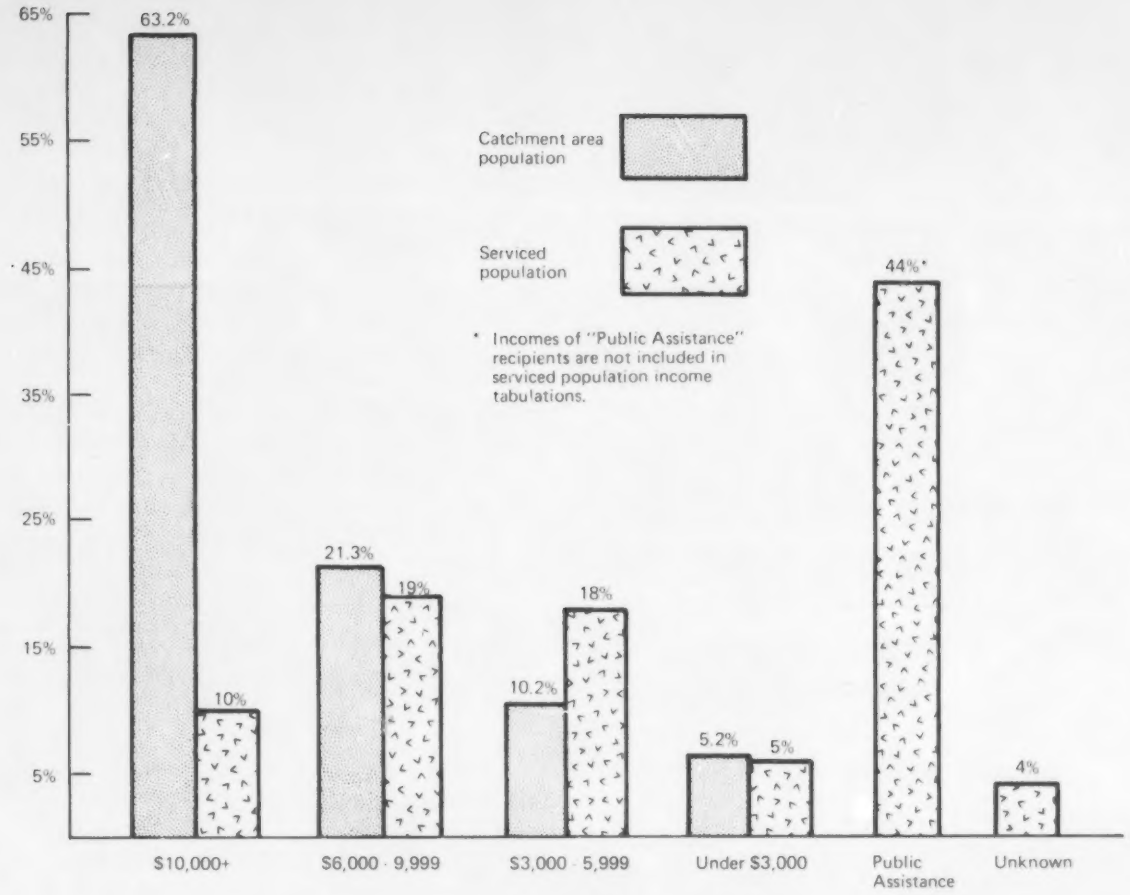


Figure 11. Income of serviced and area populations

FACILITIES

The program uses the facilities of the county welfare department. Since the staff maintains desks on a large and open floor, with the exception of a few rooms, there are no facilities available for private meetings or discussions.

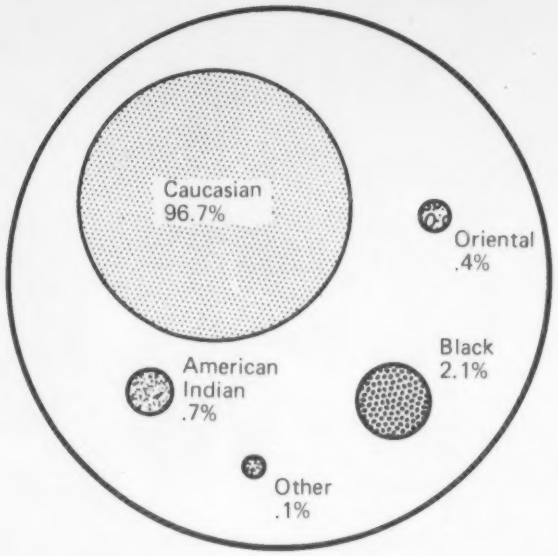
COMMUNITY AND PARTICIPANT CHARACTERISTICS

The population of Hennepin County is 960,080. Comparable data on the general population and on abusive families and children served by the program are available in four areas: income, ethnic status, intact v. single parent family status, and age.

As can be seen from figure 11, abusive families are underrepresented at the higher income levels and overrepresented at the lower income levels. Whereas 63.2 percent of the general population has incomes of $10,000 and over, this is true of only 10 percent of the abusive families.

As can be seen from figure 12, whereas 96.2 percent of the total county population is caucasian, only 70 percent of the abusive population is caucasian. Both blacks and American Indians are overrepresented in abuse cases which may be a function of income level. In other words, Protective Services addresses a disproportionate number of low income families; in keeping with the facts that minorities are overrepresented at lower income levels, the program has a disproportionate number of minority families.

Comparisons between the general population and the abusive population in terms of the pro-



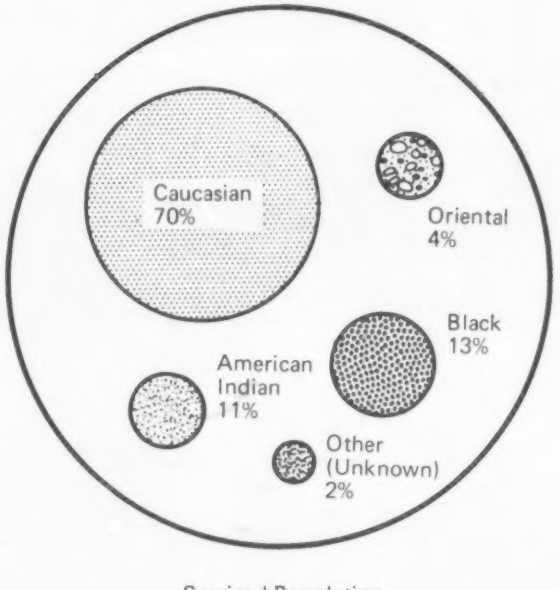


Figure 12. Ethnic breakdown of area and serviced populations

portions which are female-headed show a marked difference, as seen in figure 13. Whereas 89.7 percent of the families in the general population are intact, only 40 percent of the abusive families are intact. Since it is well known that single parent families have less income than do two parent families, it may well be that the relatively low income level of the families is, at least in part, attributable to single parent status.

As presented in figure 14, the majority of children known to the program are 0-4 years of age (55 percent), while fewer than one-third are 6 and over. This is in contrast to the fact that children 0-4 represent only 8.5 percent of the total population of 300,000 minor children.

HWCD data show that in 1974 the average monthly caseload size for abuse *and* neglect was 699 families and 1,901 children. Court involvement was initiated in 11.2 percent of the families

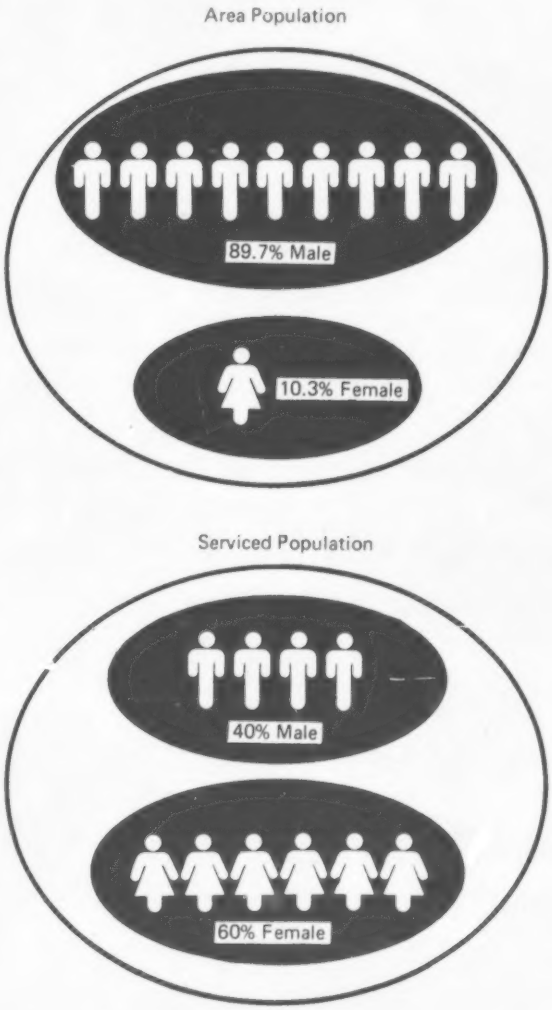


Figure 13. Area and serviced populations by head of family

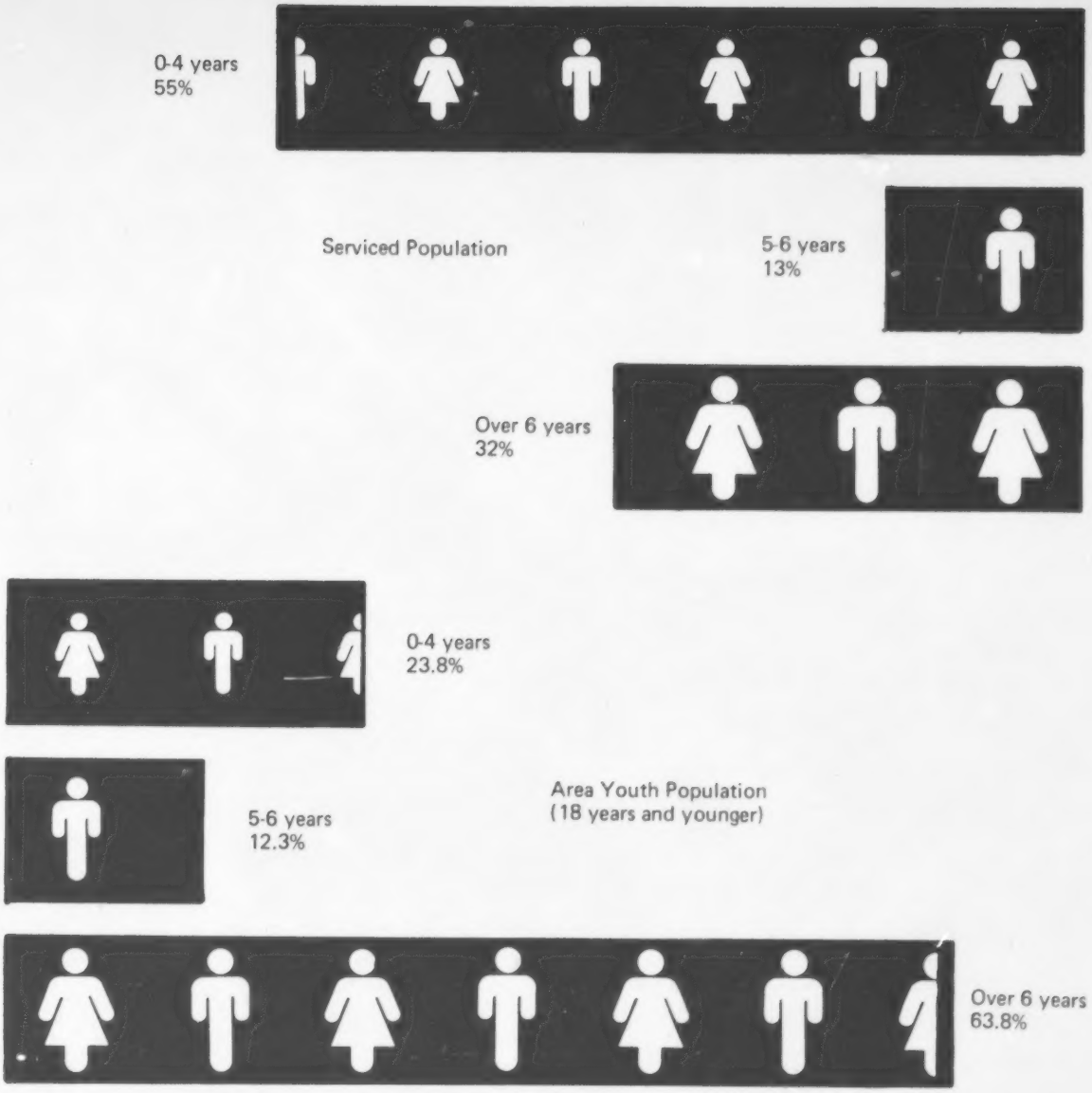


Figure 14. Number of youth among serviced and area populations

and 22.8 percent of the children were in placement. Of the 470 children in placement in May 1975, 37 percent had already been in placement for 18 months or more. Half of these children were in placement as a result of voluntary agreements between the parents and the HCWD and half as a result of court orders giving legal custody to the agency.

THE STAFFING OF PROTECTIVE SERVICES

Protective Services is headed by a program supervisor who supervises the four field units and the assessment unit. The staff organization within Protective Services is depicted in figure 15.

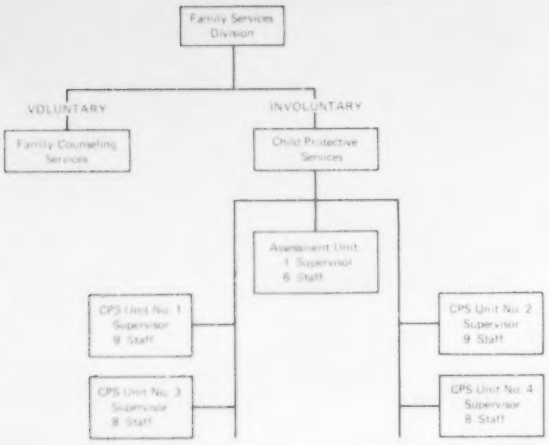


Figure 15. Staff organization

Supervisors

The one assessment and four field unit supervisors have both administrative and supervisory responsibilities. Supervisors bear administrative responsibility for ensuring that county recording demands on all cases are met quarterly, for the decision to either remove or return a child to its home, for the decision to move toward termination of parental rights through the courts. In addition, the supervisors interpret policy and procedures to the staff within their unit.

The abuse unit maintains careful records of demographic characteristics and abuse-related statistics, e.g., the number of new cases, the number of children in placement, the length of time cases have been opened. Recordkeeping and case monitoring are well implemented and are strong features of this program.

All of the present group of supervisors have worked in Protective Services for a minimum of 8 years. Several individuals have been there for 15 years and have been supervisors for 10 years. Three have MSWs, the remaining two have BA degrees.

Principal Social Workers

The persons who staff both the assessment and field units are called principal social workers. Assessment workers have responsibility for accepting incoming calls, for collecting further telephone information, and for making the decision as to whether or not cases should be referred to one of the field units.

Field unit workers have responsibility for providing casework treatment and for coordinating services.

The majority of the staff has been with Protective Services for at least 5 years. Staff turnover is minimal; some of the staff have been in Protective Services for more than 20 years. Eight of the 40 principal social workers have MSW degrees, the rest have BA degrees.

Staff training is provided by the staff development unit of the welfare department and by the supervisors.

The Staff development unit develops three and four session mini-courses dealing with such topics as foster care, drug and alcohol dependency, child development, and behavior modification. The courses are voluntary and the staff is free to choose whatever seems interesting and pertinent. According to the staff members interviewed, the courses are generally of a high quality.

Some staff members take courses at the Alfred Adler Institute and at the University of Minnesota; several of the staff are on the faculty of the Alfred Adler Institute.

Because most of the staff has worked in Protective Services for many years and because supervisors have considerable administrative duties, there is relatively little opportunity for supervisory teaching at this point. Supervisors do review the entire caseload of each worker every few months but this is primarily a status rather than a process review. Staff members have relatively little opportunity to improve their therapeutic skills through the detailed discussion of a particular session or interaction. Supervisors do not carry cases so that there is no co-therapy by supervisor and worker which could serve a training function.

It is reported that workers discuss cases with each other, but these discussions seem to be more decision than process focused. Because the families served tend to be crisis ridden and because the incidence of new cases has risen from an average of 12 to an average of 22 cases per month, there is virtually no time for reflective review of the treatment process with any given family. Because new cases tend to be extremely demanding, the supervisor in one unit has tried to handle this problem by giving each worker,

on a rotating basis, a moratorium on new cases for one month.

Caseload size varies from 18 to 30; the majority of workers have approximately 24 cases.

DIRECT SERVICES

The following services are available:

- Identification
- Case management
- Treatment: Adult individual counseling, marital counseling, family counseling, individual child.
- Support services: emergency shelter, foster care, group home placements, residential treatment, group work services, 24-hour answering service, day care services (by contract), homemaker, financial and household management, psychiatric and psychological consultation.

IDENTIFICATION

The assessment unit of Protective Services receives all calls from professionals in other agencies and from the public regarding complaints of abuse and neglect. During the telephone interview, the assessment worker seeks all possible information on the family and on the circumstances of abuse. In the case of reports from agencies, the assessment worker seeks to ensure that all relevant information has been collected by the agency. If the evidence suggests that the child is in immediate danger, the police are called and asked to take the child into custody. According to Minnesota law, only the police have the legal right to enter a home without the consent of the owners.

If the child is not in immediate danger, but there does appear to be a need for intervention, the case is referred to one of the field units. Complaints are received on approximately 4,000 families per year. Approximately 3,000 of these are cases not opened, instead, referral is made to other agencies or appropriate information is provided.

The assessment unit makes home visits only rarely, so that once the initial telephone fact-gathering has been completed, and if referral to the field appears warranted, further investigation becomes the responsibility of the field staff. Approximately 45 percent of the cases are closed after a few investigatory contacts. Face-to-face investigation by the field staff is important because in cases which will become active it means that the first contact within Protective Services is with the worker who will carry the case. Thus, the system allows for continuity of relationship and takes full advantage of the fact that families are often most reachable when they are in crisis. However, this system of case assignment also requires field staff to spend considerable time conducting investigations although they would rather spend this time with ongoing cases. When the incidence of new cases becomes particularly heavy, investigation of these cases (not all of which eventually become active) becomes time consuming and counterproductive.

In terms of referral sources, data are available only on child *abuse* cases, which represent 20-25 percent of the Protective Services caseload at any one time. Data from 1974 showing the breakdown in terms of percentages of cases referred from different sources are presented in table 3.

Table 3. Sources of referral

Referral source	*Percent of caseload*
Relatives/neighbors	27
Hospitals	23
Schools/child care facilities	15
Police	11
Private physicians	6
Public health and school nurses	5
Clinics	4
Self-referred	4
Other	5

The data in table 3 represent referral information on cases which are accepted by Protective Services and do not account for the cases which are closed by the assessment unit. The public health department, for instance, makes referrals on a higher proportion of cases, but many of their cases are not accepted as cases which are in need of Protective Services. Lack of validation reflects, in many cases, the fact that Minnesota law requires that injury to a child

be physical for a determination of abuse. Protective Services is therefore limited to cases in which abuse or neglect can be shown to have an impact on the child's physical health and well-being.

CASE MANAGEMENT

One of the primary responsibilities of the field workers is the installation and coordination of whatever services may be necessary to improve and preserve family functioning. There seems to be considerable variability among staff members in terms of awareness of community resources and skill in working closely with these resources. Some families become connected with public health, a home management and budgeting aide, recreational groups sponsored by various churches and private organizations, specialized day care for children with developmental lag, and drug counseling service. Some workers coordinate so closely with school social work staff, public health nurses, and/or day care staff, that they can be said to form a genuine integrated treatment team for the family.

Approximately 11 percent of the families are brought to juvenile court; approximately 23 percent of all children on the caseload are in placement at any one time. Thus, workers have responsibility for preparing court cases and for coordinating this effort with the court unit of the welfare department and for coordinating services for and visits to children in foster care. Because up to 2 months may elapse before a case is heard in court, considerable time is spent in crisis management until a case can be tried.

TREATMENT

Protective Services offers individual counseling for parents, some individual counseling for children, some marital counseling, and some family counseling. Most of the staff with whom we spoke reported that they feel most comfortable and skilled in conducting individual counseling with adults. Criteria have not been developed for the individual prescription of different treatment modalities. It is reported that in all probability workers use the modality with which they feel most comfortable. Some workers have criteria which they use and can articulate. In families in which there is a mother without a psychological partner and young children, the mother is seen in individual counseling. In families in which there are older children, the mother will be seen alone if the problem rests with her and the children will be seen separately; however, if the problem is an interactive one and the family has some cohesiveness and ability to work together, they will be seen as a unit. Finally, if there are two adults, who function as a couple, and the problem lies within their relationship, they may be seen by the worker together. However, neither marital counseling nor counseling of individual children is common; in most cases, individual counseling is the treatment of choice. One problem is that Protective Services does not have available consultation in either family or child therapy.

The range of frequency in terms of how often clients are seen varies from once a week to once a month, or even every two months. At the beginning of treatment, when other services are being brought in, and at times of crisis, contact tends to be more frequent than when the case is well established or there is no crisis. It is estimated that cases remain active for approximately 1 year although there is considerable variation and the range is from a few sessions to many years. There is considerable emphasis on short-term treatment, on goal setting, and on accomplishment of specific limited behavioral changes. The basic philosophy is one of changing or modifying behavior rather than personality. Despite this philosophy, there are many instances in which attempts to address behavior are not central to the treatment process. Thus, there are families in which the goal is to improve relationships between mother and children; however, this is attempted by talking to the mother rather than by demonstrating activities in which the family can engage. The emphasis on short-term treatment is borne of administrative and financial pressures which do not always take into consideration the fact that many of the families are highly difficult, multiproblem families and that it may take years to modify or to teach new behaviors. Once a case is closed, there is no process of followup and no way of knowing how the family is doing unless a new report is received. It is reported that this happens in 10 percent of the cases.

While efforts are made to assign new cases in terms of a match between family needs and a particular worker's skills, the pressure of new cases means that most often a new case is assigned to the person with the smallest caseload.

The cases which follow are intended to describe the full range of treatments in terms of process and techniques used. They also provide a picture of the kinds of cases with which Protective Services' staff works.

The first two cases illustrate a behavioral approach with the use of short-term treatment goals and the creation of contracts regarding the changes which have to be made.

Penny

Penny is a 24-year-old woman of limited intellectual abilities who grew up in institutions for the retarded and for delinquents. Her own family background is characterized by alcoholism, abuse, financial instability, and general chaos. When she was 17, she became pregnant while in a correctional institution, and, under voluntary agreement, the baby was placed. At 18, Penny was discharged from the institution and became pregnant again. By the time the second child was about 1 year old, Penny was quite neglectful of the health of this little girl, and Protective Services took the case to court. The results of the court action were termination of parental rights on the first child and legal custody by Protective Services of the second child who remained in the home.

The home situation was quite chaotic: Penny had multiple lovers and there were frequent scenes of violence, including shootings, evictions, etc. In addition, although the little girl, Melanie, was anemic and required special medication, Penny neglected to bring her in for clinic visits. The public health nurse working with Penny and Melanie felt that the level of care was so poor that Melanie should be removed. During this time Penny gave birth to a third child.

The worker began by establishing very specific goals with Penny which centered on stabilization of the housing situation, meeting Melanie's health needs through regular doctor visits, and enrolling Melanie in a day activity center for developmentally delayed children. Penny expressed considerable concern that the worker would remove her children and each time the worker made it clear that removal of the children was in Penny's power because if she met the goals the children would not be removed. Thus, this fear of the power of the worker was turned to constructive use in terms of the establishment of concrete behavioral goals. Specific contracts were worked out with Penny and used as a basis for the 6-month court reviews. Specific tasks included: getting an apartment, purchasing furniture, allowing no people with guns, and working with the home health aide on how to do laundry and shopping. Prior to each 6-month review, the worker would tell Penny that a progress report was due and would encourage her to share in making an assessment of progress toward each goal. In this manner, Penny was able to see her own accomplishments which provided her with tremendous positive reinforcement.

During this time Penny began to gain an understanding of what was expected of her so that when the worker would come for her weekly or biweekly visits, Penny would show her what was in the refrigerator in the way of nutritious foods, would show her birth control pills and the fact that she was on the right date. Currently, Protective Services no longer has legal custody of Melanie, and Penny interprets this as considerable progress on her part.

Protective Services is still involved in the case although the worker sees Penny less frequently, particularly since others in the community are aware of Penny and her needs and make sure that the worker is informed of any problems. Staff at the health clinic call the worker not only if Penny and Melanie miss an appointment, but also if Penny seems upset or uneasy. Both children are in day care centers with staff that are responsive and knowledgeable, so that they too stay in touch with the Protective Services worker. Termination is being planned, the problem being that Penny appears to do much better when her activities are monitored and when she has to be accountable to someone.

Gary and Suzanne

In their mid-thirties, this is a couple with four children, ages 4-9. Both parents are considered to be of limited intelligence; Gary spent his adolescent years in an institution for the retarded. Suzanne is not only of limited intelligence but she is also quite hypochondriacal, complaining of a variety of symptoms and calling the rescue squad for minor injuries.

At the time of referral from another county, one of the children was in placement in foster care. This child had severe temper tantrums, had set a fire, and had chased one of his siblings with a knife. Since the child had already remained in placement 6 months beyond the legal order, the

worker initiated regular visits of the child to the home and eventually he was returned.

Initially, the social worker began to work with Suzanne around getting her to be less interfering with Gary's work. Suzanne called him at work many times a day to report on her health and/or other minor events, so that it had always been very hard for him to hold a job. The worker began to point out that Suzanne was doing her job as mother and housewife very well and that she should allow her husband to do his work. In order to support this position, the worker forbade Suzanne to make phone calls to Gary and discussed the situation with his foreman who reported that Gary was an excellent worker, that he would do everything possible to help, and that if there were any problems, he would call the worker. It was also worked out that Gary could call home every day at noon and in this manner Suzanne could count on limited, but regular, contact.

Once Gary's employment situation had stabilized, the worker provided Suzanne with the services of a financial counsellor who went over their budget and showed Gary and Suzanne very concretely how much was coming in against how much was going out in terms of fixed expenses. This served to convince them that they could not afford a car and caused Gary to seek overtime whenever possible.

Both parents experienced considerable difficulty in child management, with the result that the house was invariably in chaos, they never ate as a family, and the children were often out of control. Having a relationship of 5-months standing with Suzanne, the worker initiated a series of family counseling sessions. A system was worked out whereby each child was assigned specific tasks and the completion of the tasks was marked on a chart with gold stars. The gold stars were initially tied to a small prize from the worker and ultimately to an allowance. This simple, but effective, use of behavior modification has led to far greater cooperation among the children.

The worker has also invested considerable energy in locating additional supports for the family. The child who had been in placement spends alternate weekends with a maternal uncle who genuinely likes him; a kinship family which has adopted the whole family and takes them on an outing once a month has also been located. In addition, the neighbors who rejected this family because of their strange looks and manners and initially threw mud and food at the house and taunted the family have become supportive and caring in their attitude toward the family. This shift can be attributed directly to the worker's intervention in that she met with all the neighbors over several sessions and helped them to see the need for them to be helpful and protective to the family.

Currently, the family is protected within the neighborhood and actually has a sense of belonging. Suzanne has joined her neighborhood church and is singing in the choir, Gary is doing well at his job, and the children are doing well at school.

This is an especially interesting case because it is one about which all previous professionals felt hopeless and that little could be accomplished. It is also a case in which other professionals have urged placement for the children because of the intellectual limitations of the parents. Despite these limitations, with specific step by step assistance there has been marked improvement in the family's functioning and in everyone's actual behavior. At this point, the family is living in their own house, meeting payments, and has a sense of identification with the community in which they live.

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While the previous two cases are illustrative of a large group of the Protective Services caseload in that the families are low income families with limited resources and facing considerable stress in their day-to-day functioning, the case of Natasha, which follows, is more illustrative of middle class families and of an individual with severe emotional problems.

Natasha

Natasha is a 22-year-old woman who grew up in a middle-class home and was valedictorian of her high school class. At the university, she became involved in an intense relationship (her first) with an African student. When she became pregnant, he made it clear that he had no intention of marriage and that he did not plan to take her back to Africa with him upon graduation. Upon his urging, Natasha had an abortion but soon became pregnant again. This time she refused to have the abortion despite the fact

that he told her that if she had the baby he would terminate the relationship. She had the baby and began to pursue him, going to his fraternity house in the middle of the night, making suicide gestures, and referring herself to the university health clinic in an attempt to manipulate him into a resumption of the relationship. When none of these maneuvers worked, she began to let people know that she might force him to take notice if she killed, or in some way hurt, the baby. Based on these threats, a social worker at university hospital referred her to Protective Services. At this time, while nursing the baby, she was also starving herself and living chiefly on alcohol so that a public health nurse, who had been called in on the case, was also extremely concerned.

The Protective Services worker made several attempts to visit Natasha who refused to open the door unless the worker produced "either a court order or the baby's father." The court unit of the welfare department reviewed the case, but felt there was not sufficient grounds for a court case.

Within a week, Natasha was threatening to cut off the baby's arms and legs to send them to the father and at this point a court order was obtained and the police accompanied the worker in order to take custody of the child.

While the apartment was totally destroyed in the sense that all dishes were broken, the furniture was upside down, and empty liquor bottles littered the floor, the baby was intact. Following the court hearing, the baby was taken in by the maternal grandmother and contact was established between Natasha and the worker. Soon after this initial placement, Natasha shaved the baby's head which so upset her younger brother that he tried to intervene and took a swing at Natasha while she was holding the baby. At this point, Natasha asked for a placement for the baby which was arranged.

For the next 3 months, the worker saw her every week and they developed a strong relationship. Natasha was encouraged to resume her personal relationships, go back to school, and date others. After the first 2 months, the baby came home and Natasha continued to do reasonably well.

At this point the case is closed and unless further problems occur there will be no further contact. Potential problems in a mother-child relationship are not considered to be within the domain of Protective Services which is defined as an involuntary service for children in actual danger of harm.

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The following case illustrates the manner in which Protective Services workers function vis-a-vis a court which is strongly legalistic and which places parental rights above the rights of the child. This case, as well as the next one, also illustrates the long-term nature of many of the cases, the multiple foster home placements which many children experience, and the lack of therapeutic services for children who have massive problems and difficulties.

William

This case has been with the same worker for 3½ years and was originally referred by another county. William was divorced by his wife who then disappeared leaving him with two children aged 4 and 6, who had spent most of their lives in placement. When William remarried, the children were returned to him by Protective Services in the other county without any preparation or period of reintroduction. At this point, the case was referred to Hennepin County.

Initially, the worker tried to help both parents to deal with the children. The stepmother was unused to parenting and William was accustomed to doing his work and being free to watch television. In this setting, she became more and more frustrated and angry and finally brought the children to a private social service agency for placement. She became angry while there and stalked off leaving the children to run behind her. The 4-year-old boy stopped in the street to fix his shoe and since she did not wait for him he got lost and was picked up by the police. Both children were then placed in a foster home.

The worker continued to try to work with William and his wife. The foster home did not let the worker know that there were any difficulties with the children but after 6 months they asked that the children be removed. Since it was felt that the children supported each other in their misbehavior, they were placed separately. The boy is still in the same foster home. The girl was placed in a second foster home, but after a while that foster home requested that she be removed and she was placed in a treatment foster home. This is defined as

a home in which there is a social worker who visits the children weekly and the parents participate in a bimonthly group for foster parents.

Both children continued to visit William and his wife approximately once a month. These visits were discontinued when the girl disclosed that William had forced both children to perform fellatio on him on several occasions. Prior to the termination of the visits, the worker tried to discuss with William the fact that he should make plans to engage in activities with the children. The worker pointed out that William should get his work on the car done before the visit, but since William was never taught to play with the children and had no experience either in playing or in expressing affection, it is not surprising that the visits ended badly.

William then was referred for psychological counseling, but it was felt that he did not make any major progress. It also began to appear that his wife would never accept the children and that Protective Services should move for termination of parental rights. However, it was also decided that the children were not readily adoptable and that therefore the court would be unlikely to terminate parental rights.

Therefore, it has recently been decided to allow renewed contact between the children and their father, although it is clear to everyone that the children will never be able to go home. At present, Protective Services is hoping to find another foster home which will be willing to keep the children until they can legally be on their own.

William and his wife have had their own child and much of the worker's time during visits centers on an effort to help them deal appropriately with that child since the mother was spanking the infant and William has no idea of what a father is supposed to do. Discussion centers around how important it is to perceive this child as an individual and the worker tries to interpret the child's needs to the parents.

Jack

Jack has four children of preschool age and was in the armed forces when deserted by his wife. The children were picked up by the police and Jack was brought home. Jack tried to make a home for the children for 6 months, but then asked Protective Services to place the three girls: ages 6, 5, and 4 months. The children were placed together, but after a while the foster mother asked to be relieved of the children who were too much for her. The oldest was given a new foster home and placed separately from the other two girls.

After about 1½ years, Jack, who had a drinking problem, remarried. He and his new wife decided that they did not want the oldest child, who really belonged to his exwife and was not his. During the process of seeking termination of parental rights and trying to locate the natural mother, the mother was found and she and her new husband decided to try to make a home for the eldest child.

Plans were made to return the other two children to Jack by the end of the school year; in the meantime, his wife had a baby. The older of the two children began to deteriorate in foster care and the foster parents did not know how to handle her. In the meantime, Jack decided that he did not want the baby back and that he wanted to terminate parental rights. In light of this development, the natural mother decided to take the child, but after 3 weeks the mother called Protective Services and told them to come and get the child before she "dumped her." The child was then placed in another home and it was agreed that termination of parental rights would be appropriate. This child was then adopted.

The middle child remained in foster care until the foster family requested her removal. After a weekend home visit, Jack decided to try once again to keep her. However, this worked out badly because the little girl was extremely hostile to her stepmother and tried to come between her and Jack. The stepmother agreed to participate in counseling if the child was removed from the house. Once again the child was placed in yet another home and the Protective Services worker is hoping that Jack and his wife will reach a point where they can take the child back. However, the stepmother is characterized as a flighty woman whose own children are living with her grandmother. Moreover, there are severe conflicts between Jack and his wife in terms of how discipline should be handled.

The worker generally sees Jack and his wife together, although sometimes he sees her alone. The discussion focuses primarily on the marriage and the child is not included in the sessions. When the child was home and the worker would

visit, the child would keep coming into the room and be told by the parents to leave. No one is working therapeutically with the child.

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The last two cases described illustrate a holding action and an attempt to deal with frequent crises and extremely difficult family situations. The results tend to be multiple foster home placements for children, lack of change by parents, and an end result where the children are too disturbed or too old for adoption.

In one of the units, an effort is being made to set up specific goals with the parent who wants voluntary placement to ensure that placement does not merely become a convenient means for storing children. The idea is to agree to the placement if the parent agrees to work toward meeting certain goals. If the goals are met, the child would come home and if not Protective Services would take the case to court so that the judge's authority can be used in terms of goal setting. At this point the contract would be with the court as well as with Protective Services. This contract would be reviewed and if the conditions were met the child would return home, but if not, parental rights would be terminated.

The following two cases illustrate the massive problems of many of the families and the fact that often there are so many needy clients within a family that no one receives sufficient service. In addition, these cases, like the two previous ones, highlight the need for social work intervention for children who, by and large, do not receive any systematic help.

Paulette

Paulette, whose divorced husband is a professional, has five children ages 18, 16-year-old twins, 14, and 11. All of the children are reported to be unusually gifted and all of them are disturbed. The eldest, Alex, is a drug addict who has been in and out of residential treatment centers in the past couple of years and is currently just drifting; the 16-year-old twin is home with his mother, who is seriously disturbed and barely manages to care for him; his sister is locked in a symbiotic relationship with a foster mother who is felt to be seriously disturbed, but the girl will not give her up; the 14-year-old son is living with a friend, has been on drugs, and is not expected to return home; the youngest son lives at home following stays in three treatment institutions. This youngest child is being worked with by another Protective Services worker in the unit.

Paulette, herself, as a function of an extremely active and supportive therapist, is doing better. She is working, has improved greatly in her physical appearance, and has developed a strong dependent relationship with her worker.

The worker in this case has mobilized many resources including Ala-teen, medical facilities, the Department of Vocational Rehabilitation, court services, temporary shelters and foster homes, drug treatment facilities, school social workers, and mental health facilities. The worker continues to see the mother biweekly and helps her in her day-to-day living arrangements. Family therapy has been ruled out because it is felt that the family lacks sufficient cohesiveness. The primary focus of the treatment is on providing support and positive reinforcement to Paulette while helping her to cope with her crises-ridden life.

Jill

Jill is divorced from her husband and has been confined to a wheelchair for the past couple of years following an accident. The accident affected both her mobility and her intellectual capabilities although there has been no assessment of the degree of cognitive impairment. Her children are a 17-year-old girl, a 12-year-old boy, and a 10-year-old girl, all of whom live at home, and a 16-year-old boy who lives with a paternal uncle. Following her accident, Jill was hospitalized for alcoholism and was then referred to a private social work agency for counseling. She never made a real connection with the assigned worker and was referred to Protective Services to see if she could function and provide appropriate care for the children. It was decided that the family could function if everyone were to cooperate.

Initially, there were marked problems between Jill and her 17-year-old daughter, which the worker attempted to mediate. When this approach met with little success because of the girl's unresponsiveness, the worker began to concentrate more on Jill. Efforts were made to work with her, to provide her with a home management aide, and to coordinate with her lawyer. Jill has invariably missed appointments with the aide who has therefore been unable to

help her with budgeting, cooking, shopping, etc. Her lawyer feels that she is incompetent and has given up on her. The worker was able to induce her to go for physical therapy and she did continue until discharge.

The 12-year-old boy has become more of a problem in school and the worker has tried to coordinate with the school social worker. Now that the Protective Services worker is providing transportation services for him to a group meeting which he likes, he is beginning to relate somewhat. The boy is feeling depressed and anxious and is acting out to the point where he is in trouble with the law. Up until this time, no one has systematically worked with this boy. He has not had an opportunity to talk about what his mother was like before the accident, about the accident itself, or about his putative father leaving; he only learned in the last couple of years that the man was not his real father and he has not had the opportunity to discuss that either.

At this point there is considerable question as to whether or not the son can remain in the home because Jill provides him with so very little supervision or structure. Psychiatric help for the boy is being sought; however, massive work will have to be done in terms of teaching an adaptive relationship to mother and son, if they are to continue to function together.

THE SERVICE DELIVERY SYSTEM

This section provides information on some of the community agencies within Hennepin County that have contact with abusive adults and/or their children and their relationship with Protective Services.

The level of awareness of abuse and neglect is high among health service personnel in general. At the county general hospital all nursing staff, medical students, interns, and residents rotating through the pediatric service, as well as all clinic, house, and social service staff receive special training in the identification, reporting, and handling of suspected abuse cases. There is a formal protocol for these procedures which is based on the principle that if there is *any* suspicion of abuse or neglect, staff should try to admit the child to the hospital so that further investigation may proceed without endangering the child.

The hospital has also developed procedures and programs targeted at the prevention of abuse. The records of all families who fail to keep appointments or who otherwise seem negligent in providing medical care to their children are labeled "social high-risk." A clinic social worker makes contact with each such family while another pediatric social worker is assigned to the hospital's newborn intensive care unit in an effort to establish a casework counseling relationship with high-risk mothers before an abuse incident occurs. In addition, this worker and a social worker from the hospital's Child-Adolescent Mental Health Center have begun a preabuse therapy group. At present, there are eight persons in the group who have voluntarily agreed to participate because they have identified themselves as parents who have difficulty controlling their aggressive impulses and disciplining their children. Referrals to the group are made from a variety of community agencies, however, known abusers are not included and the group is not intended for them. It is the hope of the co-therapist that if referrals continue additional groups may be formed.

At the Children's Hospital, it is the staff of the department of mental health who provide intrahospital training in abuse and neglect. Hospital social workers are assigned responsibility to train all medical personnel in the procedures for handling cases of suspected abuse or neglect in accordance with Minnesota law. In addition, each social worker is charged with providing inservice training to the staffs of hospital departments. For the most part, such training consists of sessions on child development and on methods of working effectively and sensitively with parents. As in the General Hospital, records of abusive families are specially marked; however at Children's Hospital this is true only of mental health unit records, not of medical records in general.

Children's Hospital also sees prevention of abuse as an important focus and is concerned with providing more intensive services to those families seen as high-risk for parenting. Social workers are present at comprehensive clinic staffings at which such high-risk cases are discussed by all personnel having some involvement with the family. Also present at these staffings is a liaison worker from the Hennepin County Child Protection Service, assigned to the hospital for ½ day per week. The presence

of the liaison worker is considered important by social service staff in terms of coordinating available services for a family. In particular, because the hospital does not have a sufficient number of social workers to do outreach, it is felt that the liaison worker may help in moving cases through to Protective Services so that outreach service may be provided. In addition, the mental health department of Children's Hospital conducts two therapy groups for single parents who have been identified by the department in the outpatient service as being high-risk for parenting. Participation in the group is voluntary and each group is scheduled to run for eight weekly sessions although members may renew their contracts and continue in the group. Individual and family counseling are provided in addition to group or in those cases where the parent is seen as being inappropriate for group therapy.

The city health department unit staffs, which are drawn from public health nursing, preventive nurse counseling, social work, maternity, and infant and child care, are all trained in and sensitive to the detection of abuse and neglect. Through its comprehensive child care, prenatal and family planning clinics, the department services more than 6,400 children and 700 pregnant women each year. Here also, the primary focus is on prevention. Eight years ago, the social service unit of the department began designating the records of high-risk families as such. However, approximately 3 years ago the department undertook to place a new emphasis on the detection of high-risk abuse/neglect families. At that time, the department was reviewing its records to determine what were "child killers" and found that while there were only two deaths among children known to the clinics, both deaths were caused by abuse. It was then that intensive staff training efforts, which are now ongoing, began. In addition to intraagency training, representatives from the department have conducted training sessions at other community agencies, including the Hennepin County Child Protection Service Unit.

The new State child abuse reporting law, which is currently awaiting the Governor's approval, will for the first time mandate reporting by all school personnel. Prior to this law, school personnel were reporting cases as they came to their attention but the level of training in detection and coordination around serving abused children was not high. School personnel had been given one inservice training session dealing with abuse; for the most part, the school social workers were the persons who worked with the abused child. In preparation for enactment of the new law, more intensive efforts are being made in the areas of training and coordination. The social work department of the school system, in conjunction with school administrators and health personnel, has developed guidelines and an action plan for the coming Fall which includes adoption of formal reporting procedures, the establishment of a data collection system, and the creation of an extensive program of staff development for all categories of school personnel. As they are presently formulated, the procedures emphasize the use of a team approach in each school such that the administrator, social worker, and nurse will work together to coordinate services for the child and his family.

Within probation units of the department of court services, consideration is being given to inviting Protective Services to conduct an inservice training session for workers. Because of the way in which cases come to the attention of probation, workers are not seen as having to deal directly with abuse. That is, if a child is abused by his parents, this child will not become a probation case. However, if an abused child commits a delinquent act, he may be placed on probation, but the presenting problem, and therefore the area of investigation and concern, will be delinquency, *not* abuse, despite the fact that the delinquent act may be in response to parental abuse. It seems, however, that there may be a growing awarenesss of a large number of delinquency cases in which abuse is also present and that this awareness may become manifest in implementation of abuse/neglect training sessions.

Interviews conducted at a number of community agencies reveal a sense of frustration on the part of staffs involved with abusive families in terms of the level of coordination with, and feedback from, Child Protective Services. While this lack of coordination is not felt to be true of all protective workers, expressions of frustration were uniform across all community resources. Although Protective Services is the agency mandated by law to manage all cases of abuse, services to abusive families are provided by a number of agencies in addition to Protective Services. These agencies feel they should

be in closer contact with Protective Services around cases. A number of agencies have recommended that an interagency coordinating team be established which would staff cases, but Protective Services is against the team approach and views it as an attempt by other agencies to impinge upon the authority of Protective Services. Protective Services feels that because they have the sole responsibility under law to provide protective services, they should also have sole authority. It is also strongly felt that improvements in terms of case management and treatment procedures should come from within and not at the urging of other agencies.

Efforts have been initiated by some community agencies to further communication but the results have not been satisfying to these agencies. Some resources, in making an abuse report to Protective Services, write across the report that they wish to be informed of the progress of the case; other agencies write that they wish to know when Protective Services will be making an initial visit to the family so that the agency can follow up with the family and the worker; agencies report that if they make telephone calls to Protective Services following a report they will frequently, but not always, be able to obtain this information. Representatives from agencies which are dissatisfied with coordination and communication lines to Protective Services are quick to point out, however, that many of their line workers have excellent relationships with line staff at Protective Services. The difficulties are seen as a problem within the "system."

Health agencies, i.e., the hospitals and the public health agency, also report that many of the cases they handle are not accepted for services. Failure-to-thrive cases reported by health agencies are often not accepted by Protective Services because they are not sufficiently serious. While criticized for the cases they do not take, Protective Services reports that the cases they can take under the law are limited and they are careful not to misuse the statute.

COMMUNITY EDUCATION

Some of the Protective Services staff are especially active in community activities centering on child abuse and neglect. There is a speakers bureau, and the supervisors, as well as some workers, give many speeches at hospitals, day care centers, schools, and other community agencies and groups.

The supervisor of the abuse unit has served as chairman of the statewide task force, which held 26 meetings to draft the new Minnesota child abuse legislation. He has also served as the chairman of the Hennepin County Child Abuse Council, which was formed as a mechanism for providing education to service providers in other agencies. However, in the past year the council has been largely inactive.

Protective Services also puts out a variety of publications on its child abuse activities which it disseminates to other county welfare departments.

SUMMARY OF KEY FEATURES

This is a protective services program within a public agency which has been able to mobilize adequate resources in order to maintain caseloads at a relatively manageable level. Many families, in addition to the usual array of concrete services, are given the opportunity to work on their problems in a fairly intensive treatment relationship. If caseloads should climb much beyond 20-25 families per worker, the treatment components of the program are bound to be eroded.

The Hennepin County program illustrates the level of service which can be expected in a well organized program with a committed staff with considerable experience and training and manageable caseloads. One very important feature of this program is its continuity of service. The family's first contact is with a field worker who continues with the case even when the children are placed in foster care. The program also represents one well-articulated, if controversial, point of view about the nature of working relationships and linkages with other community agencies.

Lehigh-Northampton Counties, Coordinated Child Abuse Program, Pennsylvania

by Monica Holmes, Ph.D., and Dorie Greenspan

Director PROTECT: Helen Ruch, MSW
Program Coordinators: David Lehr and Philip Coleman, MSW

START-UP

This is a two-county program which owes its origins to the experience of a local pediatrician who, in the fall of 1969, had several abuse cases in his practice in both counties. He was unable to find any resource to which the abusive parents could be referred for psychotherapy in either county. Because there was no available institutional resource, the pediatrician approached a local psychiatrist who was known in the community for his work with groups. The psychiatrist agreed to try to work with an abusive group, but from the beginning sought the involvement of the Children's Bureau (CB), the local public child welfare agency. Thus, the first therapy group for abusive parents in Lehigh County was started with the psychiatrist and the Children's Bureau caseworkers as co-leaders. This first group held its first meeting in November of 1969 and served residents of both counties.

Nearly 1 year later, the director of the Mental Health/Retardation (MH/MR) service referred an abusive family to the group, and herself joined it as co-therapist. In this manner, the important linkage between CB and MH/MR, which is at the core of the present day program, was established. MH/MR was responsible for the group therapy program and CB was responsible for providing casework and coordinating supportive services. Initially, any CB caseworker working with a client who was also in the therapy group had responsibility for participating in the group with his client(s).

By the fall of 1971, the CB directors in each county concluded that use of all protective services staff in the therapy group was inefficient; thus, one worker within each county was made responsible for all child abuse cases. In February of 1973, in response to increasing demands for service, a second group with clients from both counties was started in Lehigh County.

By the spring of 1973, it had become increasingly clear that there was a need for enhanced service coordination and heightened public awareness relating to child abuse. Community agency representatives, community professionals, and several consumers (former abusers who had graduated from the group) joined in an effort to develop a proposal to the Pennsylvania State Department of Public Welfare for funding. By the fall of 1973, this group had become known in the community as PROTECT. While never incorporated, this group has continued to function in an unofficial advisory capacity. Incorporation was considered for the purpose of eligibility for funding, but this idea was rejected because the CBs were already in a position of responsibility and were cooperative with other agencies. PROTECT is conceptualized as a community rather than an agency group and it is planned that in the future it will develop in this direction.

In November of 1973, a third therapy group, the first in Northampton County, was formed. The first evening group, it was designed to accommodate people from either county who could not come during the day. From its inception, this group has been led by an MH/MR psychologist and the Northampton County CB casework supervisor.

By June of 1974, it became apparent that with groups in both counties and crosscountry client and caseworker participation in all the groups, a monthly coordinating meeting was necessary. At these monthly staffings two to three cases are presented for discussion and recommendations. The staffing meeting serves a coordinating and teaching function.

In October of 1974, the program received a total of approximately $600,000 for 3 years from the Pennsylvania State Department of Public Welfare. Funds were given to the CBs in each county to establish a child abuse unit

and to hire a child abuse coordinator. Also, these monies enabled the CBs to purchase expanded services from the MH/MR, new services from the Head Start/Home Start Program, and Lehigh University's Center for Social Research.

PROGRAM OBJECTIVES

The objectives of the program as stated in the funding proposal* are as follows:

- Development and expansion of programs treating the abusive adult and abused child
- Effecting psychological changes in parents or responsible adults to prevent child abuse
- Enhancing the child's development
- Modification of the home environment in such a way as to lessen stresses which give rise to abuse
- Building the effectiveness of the training component
- Adding to our knowledge of the etiology of child abuse and of the effectiveness of different treatment programs
- Education of the community as to the nature of child abuse, the need to report incidents of it, the characteristics of abusive adults, and the availability of resources for treating abusive adults and the abused child

PROGRAM AUSPICE

The Children's Bureau serves as program auspice in each county. However, the program represents an exceptionally close collaboration between CB and MH/MR. This collaboration is unlike that in many communities in which the public child welfare agency is unwilling to share responsibility in a collaborative effort with the mental health agency, and the mental health agency has little interest in child abuse. The collaborative effort in these two counties is a function of the personalities of the key actors and of historical accident. The MSW director of the MH/MR in Lehigh County had recently transferred from a supervisory social work position at the CB, hence there was every reason for these agencies to work together in a collaborative relationship in which the thrust was on development of joint programs.

Within each county Children's Bureau there are four units: intake, protective services, placement, and the newly created child abuse units. All cases reported to the Children's Bureaus, whether abuse or protection, come through the intake unit. If, based on the initial report, the intake worker evaluates the case as one of abuse, the case is immediately turned over to the abuse unit for investigation. There are, however, instances in which abuse workers are not available and the investigations are conducted by intake staff. In such cases, the families, if abusive, are transferred to the abuse unit as soon as possible. In addition, some cases being serviced by the protective services unit in which abuse becomes active, or in which the protective services worker is concerned about the family's potential for abuse, are transferred to the abuse unit. In this way, the abuse unit workers can provide preventive as well as interventive treatment. In cases involving placement, the placement and abuse units work together so that continuity of care is maintained.

PROGRAM COSTS AND SOURCES OF FUNDING

Table 4. Sources of funding

Sources of funding	*Lehigh County*	*Northampton County**
Ongoing county support for CB	$13,500	
State grant	$121 500	$78,150
Total budget	$135,000	$78,150

*This budget has only been approved for a 9-month period, hence the $78,150 is for 9 months only.

FACILITIES

The program uses the facilities of the CBs and of the MH/MRs. Staff members from each agency use the facilities of their own agency. In Lehigh County, the groups meet in the MH/MR building which is a lovely, comfortable old house. In Northampton County, the group meets in the modern office building which houses the CB. In both counties, the CBs have

*Funding proposal, Demonstration Program on Coordination of Child Abuse Services in Lehigh and Northampton Counties.

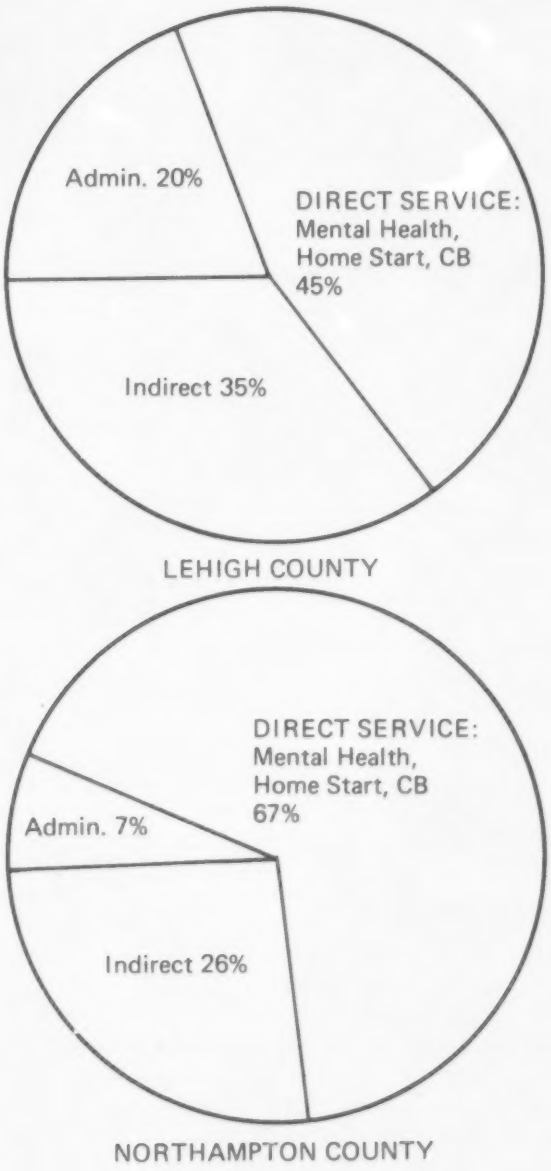


Figure 16. Budget allocation

a well-equipped playroom which is used for the children of group members during group sessions.

COMMUNITY AND PARTICIPANT CHARACTERISTICS

Lehigh County covers 351.4 square miles, with a population of 225,300; Northampton County covers 379.8 square miles, with a population of 214,360.* Data which are comparable across both the general population and the individuals served by the program are available in four areas: income, ethnic status, intact v. single parent family status, and age.

As can be seen from figures 17 and 18, client families in both counties are underrepresented at the over $10,000 income level and somewhat overrepresented at the lower income levels. It is interesting that, whereas in Lehigh County 23 percent of the client families are reported to have incomes of $3,000 and under, no families in Northampton County are reported to have such incomes. It is also noteworthy that a relatively high proportion (22 percent in Lehigh County and 36 percent in Northampton County) of client families have incomes which are over $10,000.

As can be seen from figures 19 and 20 on ethnic status, both counties have a primarily caucasian population. Both black and Spanish surname families tend to be somewhat overrepresented in the client population of both counties.

Data on intact v. single parent status are presented in figures 21 and 22. Whereas the population in both counties is generally comprised of intact families, the client populations tend to have a very high proportion of single parent families. The 35 percent of female-headed families in Lehigh County is particularly high. Certainly there is a strong association between abusive behavior and single parent status in the families that come to the attention of this program.

The age breakdown of children in the population and in client families is presented in figures 23 and 24. Whereas children ages 0-4 represent 21 percent of all of the children under 18 years of age in the general population of both counties, they represent approximately 34 percent of abused children. Thus, younger children tend to be overrepresented in the client group. Since the largest percentage of referrals comes from medical sources, it is not surprising that a relatively large proportion of children known to the program are under 4 years of age.

*Lehigh County population data are based on 1970 census data, while Northampton County population data are based on a 1975 estimate of population from a local planning agency.

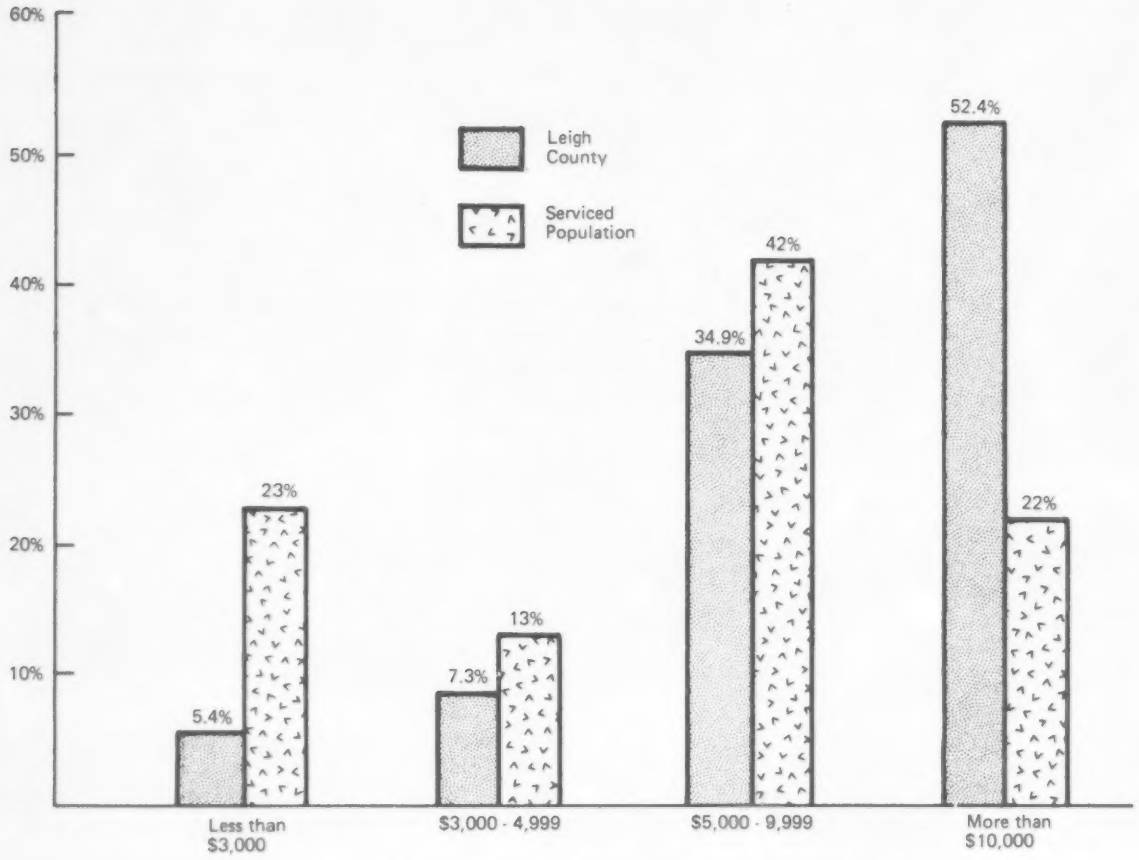


Figure 17. Income of families in serviced and area populations — Lehigh County

THE STAFFING OF THE PROGRAM

The CB in each county provides one coordinator, one supervisor with an MSW for the abuse unit, three social workers with an MSW in one county, and three caseworkers and one MSW in the other county. The MH/MRs provide three of the four group co-therapists: an MSW social worker, and a psychiatrist in Lehigh County, and a psychologist with an Ed.D in Northampton County. In addition, two Home Start workers with BA degrees and their supervisor, who has an MA in child development, provide regular services to the program's families.

While most of the caseworkers have had less than a year's experience in abuse cases, the social work supervisors, the group therapists, and one of the coordinators, have had extensive experience. Caseworkers work with from 8-19 families; 15 families per worker seems to be most typical.

For simplicity's sake, figure 25 includes only staff with direct and intense program involvement and does not include other CB and MH/MR staff who do make some contributions to the program, e.g., intake units of the CBs, psychologist at the MH/MR who does psychological assessment, and the research component, etc.

Program-related research is being conducted by two part-time (Ph.D) psychologists from Lehigh University and a full-time (MSW) assistant.

Training for CB abuse workers takes two forms: individual supervision and inservice sessions. Individual supervision, provided by the unit casework supervisors, is primarily concerned with case management although some skill development training may be provided as an adjunct to assistance with managing a case.

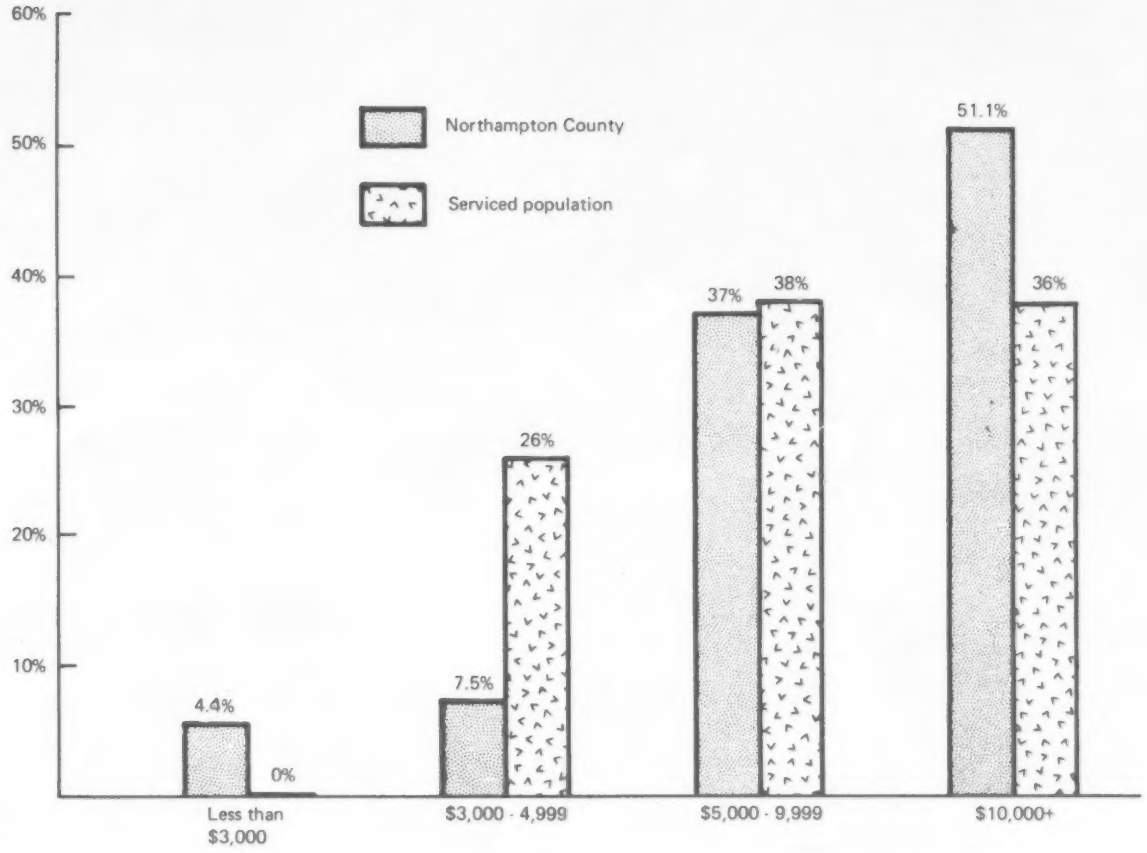
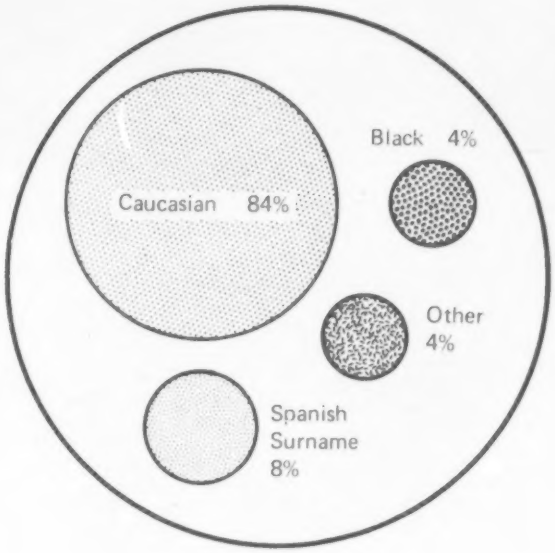


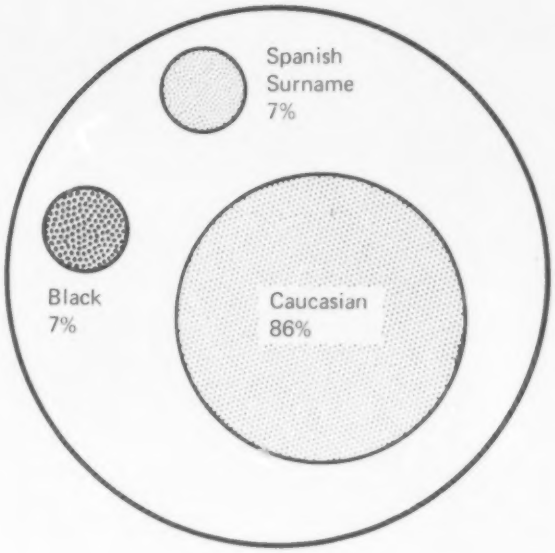
Figure 18. Income of families in serviced and area populations – Northampton County

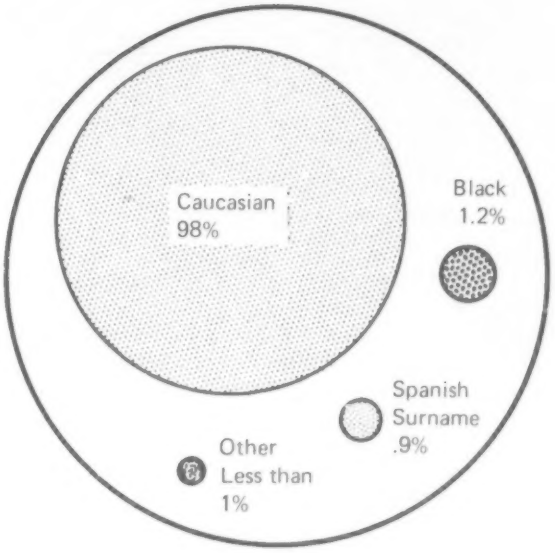
Caseworkers either participate in the group therapy sessions or observe the sessions through a two-way mirror. Discussions which follow the group meetings provide everyone with an opportunity to discuss the therapeutic events of the session.

Monthly staffing meetings also provide an opportunity for training, as the caseworkers have responsibility for presenting the case and participate in the discussion which follows. Inservice training sessions, held bimonthly, are of a more global nature, often drawing on resource persons from outside of the Children's Bureaus. For example, pediatricians have spoken on the medical aspects of abuse, a representative from Head Start has presented information on working with children, and an MH/MR psychologist conducted sessions on group therapy. Sessions oriented to agency functioning have included discussions of the responsibilities of other CB units and the administrative aspects of case management. Whenever possible, abuse unit workers are sent to relevant conferences held outside of the CBs as part of their formal training.

Until the present, Home Start parent educators working with abusive families had received their training and supervision from within the Home Start agency. While parent educators maintain close communication with abuse unit caseworkers and attend staffings, their training has been conducted on a separate basis. Arrangements are now being made to permit Home Start abuse workers to sit in on special unit supervisory meetings as well as training sessions, in an effort to further strengthen the lines of communication while drawing upon available potential for training.







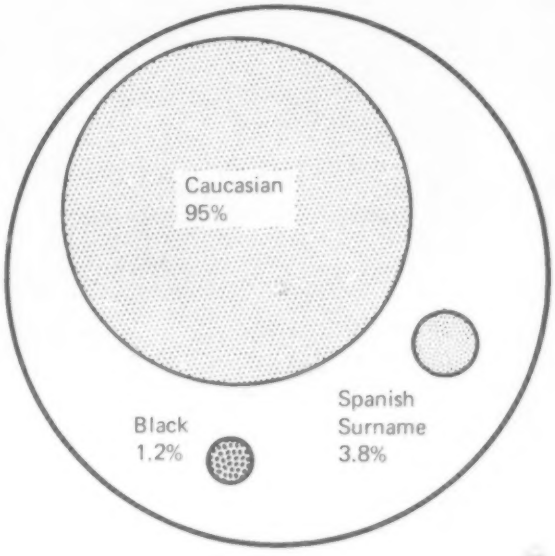
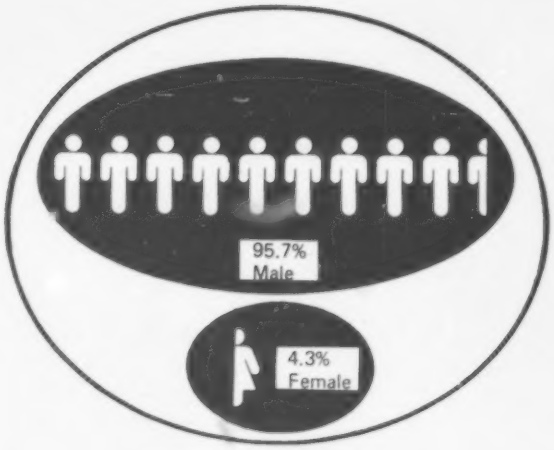


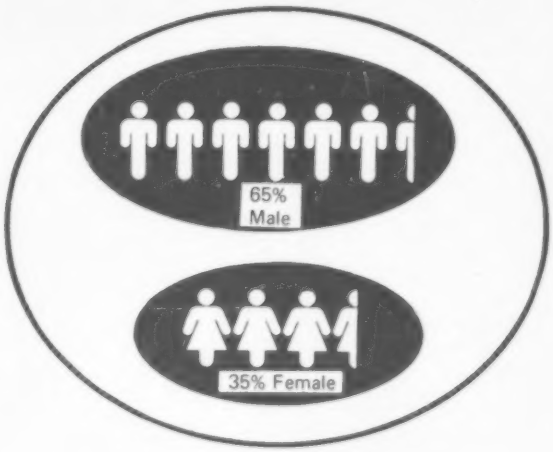
Figure 19. Ethnic breakdown of area and serviced populations — Lehigh County

Figure 20. Ethnic breakdown of area and serviced populations — Northampton County

One important concern relates to the provision of structures which encourage support among staff members. Abuse unit supervisors are acutely aware of the potentially high "burn out" rate among abuse workers. Understanding that cases can be demanding and depressing, supervisors have encouraged staff members to build close working relationships among themselves, so that they can feel that backup is available and that there is always someone with whom to discuss the emotional, frustrating aspects of case involvement.



Area population



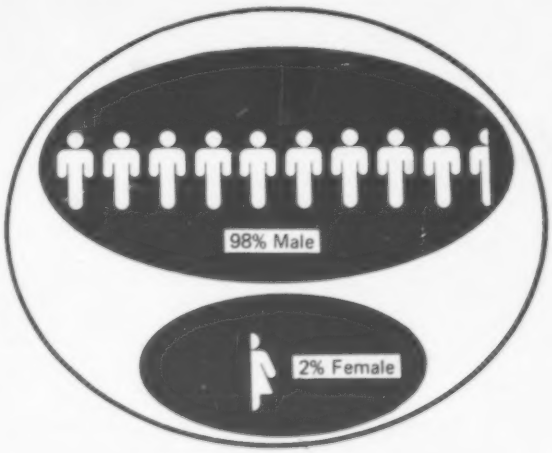
Serviced population

Figure 21. Head of families in serviced and area populations – Lehigh County

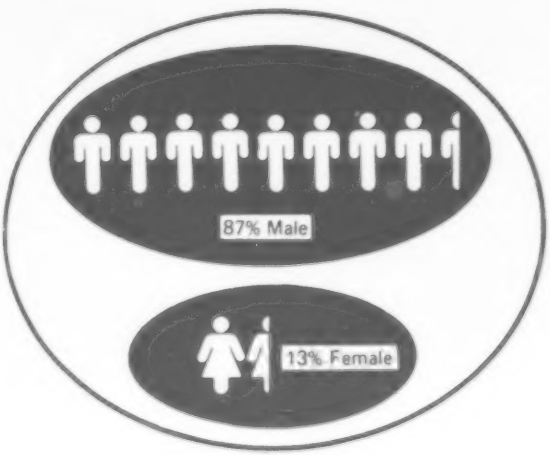
DIRECT SERVICES: PRIMARY AND SUPPORTIVE SERVICES

The program offers the following primary services.

- Investigation of reported cases
- Case management via the CB caseworker assigned to each case
- Child stimulation via the weekly group meeting for children and the weekly Home Start visits
- Treatment via casework intervention and group therapy
- Supportive services including those regularly available at each agency. CB offers 24-hour on-call service, foster care, and emergency foster care. MH/MR offers psychological assessment, as well as individual and some family therapy. Other resources in the community are used for services, e.g., the department of public welfare, public health, family services, Visiting Nurse Association
- Education of lay and professional community
- Agency coordination



Area Population



Serviced population

Figure 22. Head of family in serviced and area populations – Northampton County

Figure 23. Number of youth in area and serviced populations — Lehigh County

INVESTIGATION

In making a referral, the complainant fills out a form called the CY-47 which, following investigation, is sent to the State registry in Harrisburg. Cases in which there is medical indication of child abuse are referred directly to the child abuse unit for investigation and validation. Investigation includes a home visit, social history of the family, and interviews with relevant community persons or professionals.

In terms of referral sources, table 5 presents data from 1974 in terms of percentages of cases referred from different sources.

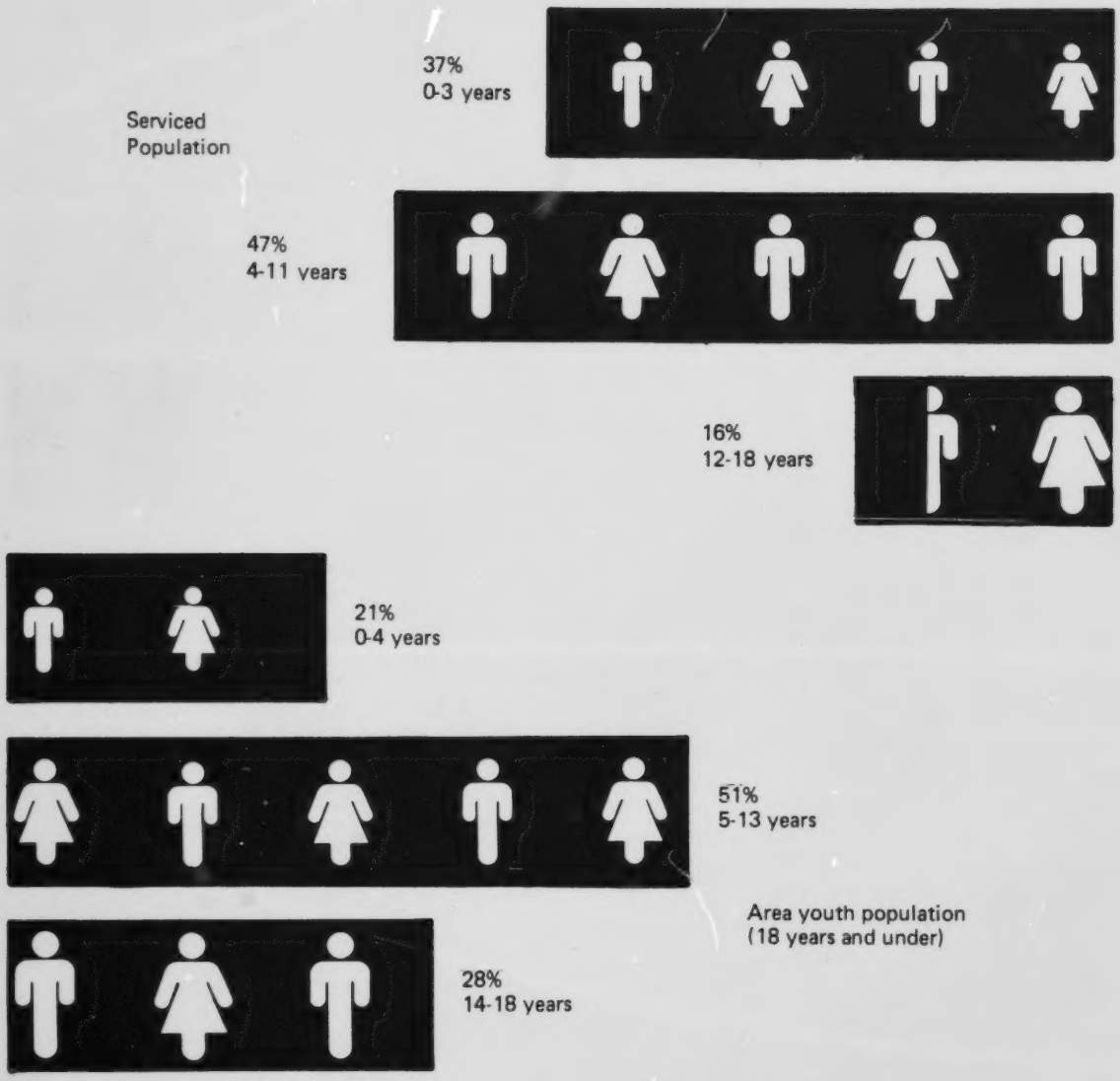


Figure 24. Number of youth in area and serviced populations – Northampton County

Table 5. Sources of referral

Resources	*Lehigh*	*Northampton*
Medical sources	80%	60%
Schools	15%	30%
Other service agencies	2%	7%
Relatives and neighbors	1%	3%
Self-referred	2%	0%
Total	100%	100%

During 1974, the Lehigh County program received referrals on 55 families, 41 (75 percent) of which were considered valid. The Northampton County program received reports on 29 families of which 14 (50 percent) were considered valid; 6 were nonvalid and 9 were not determinable. A total of 20 cases was accepted for treatment.

Currently, the Lehigh program has 55 abusive families who are in active treatment with a total of 124 children. Forty-four (35 percent) of the children are in placement. The Northampton program has 46 families in active treatment with

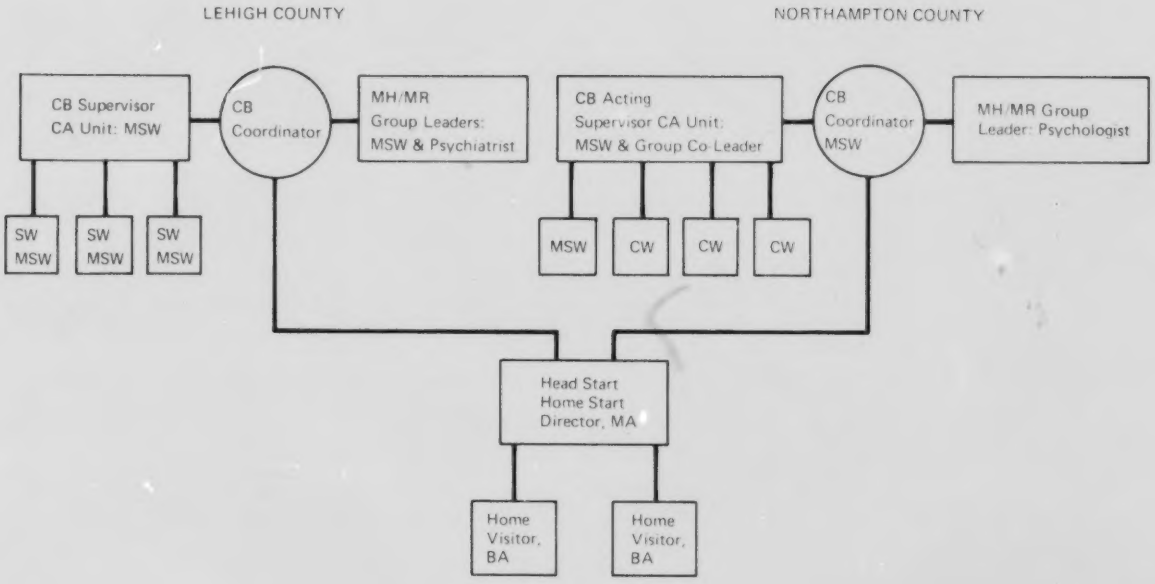


Figure 25. Program staffing

a total of 98 children. Thirteen (13 percent) of the children are in placement.

Reporting professionals as well as CB staff are encouraged to be forthright about letting families know of the report to CB and of their belief that the injury could not have been an accident. At this point (if not before) the client is introduced to the child abuse caseworker who will be directly involved in the treatment and who will, at the same time, coordinate all other services.

When it is clear that there has been abuse and that the child cannot remain at home, the parent(s) signs a voluntary placement of the child to the CB. In approximately 10 percent of all cases in Lehigh County, the parents refuse to place the child and are taken to court. In Northampton County, it is necessary to take the family to court to place a child approximately 60 percent of the time. In all cases, CB tries to offer services to the parent. Even among parents who refuse, there is considerable persistence in trying to get them to accept help. In these cases, the approach used is to agree with the parents that the abuse cannot be proven and to identify a common issue which can be addressed, e.g., the preoccupations, tensions, or lack of knowledge which led to the parents' inability to protect the child and to prevent injury. Program staff feels that the best chance for the establishment of a therapeutic alliance lies in finding a common ground for discourse, rather than in engaging in accusations or counteraccusations.

CASE MANAGEMENT

Case management responsibility rests with the CB caseworker. Each worker works with from 8 to 19 families. Families are seen in the home for 1-2 hour sessions from two to four times each month.

As part of their case management responsibilities, workers may transport clients and their children to the group meeting, may participate in the group therapy—keeping the group therapists regularly informed about new developments, may coordinate and exchange information with Home Start staff, and may coordinate health, day care, foster care, housing, and welfare services on behalf of their clients.

TREATMENT

Treatment in this program takes many forms. Individual, couple, and some family therapy are conducted by the CB social workers or by MH/MR staff. Therapists talk with the parent(s) about their difficulties with each other or in other relationships which leave them angry and dissatisfied; the inability to support and help

each other is highlighted and discussed. Similarly, the parents' relationships with their children are discussed and attempts are made to induce the parents to see their children more realistically. Knowledge of children, of developmental stages, and of alternative ways of disciplining children, are explored. Some therapists hold a series of meetings with the extended family in order to explore relationships, to help the nuclear family set limits on the intrusiveness of the extended family, and/or enlist the support of the extended family for the nuclear family. In a few cases, when older children are involved and the parents ask for help in managing the child, family therapy is recommended in an effort to reduce the amount of conflict in the family.

In a few cases, where it is felt that an older child needs treatment, children are in individual therapy at the MH/MR unit. Generally, however, children are not treated, in the strict sense of the word. For example, children living at home, whose parents participate in the group therapy, are brought to the weekly group sessions for children. These sessions, led by college volunteers, are designed to provide children ages 2-12 with a constructive opportunity for socialization with their peers in the context of a firm but supportive contact with adults. The student volunteers are supervised by the CB supervisor or coordinator. Weekly Home Start visits represent the final form of direct intervention with children.

In work with the families, caseworkers focus on improving functioning with children in the home and on maintaining contact with children in foster care. Caseworkers participate in most visits between parents and their children in foster care. If CB feels it is necessary to remove the children, the caseworker continues to work with the parent(s). As a result of their experiences with intrusive extended families and a realization that abusive parents are often locked in a hostile, symbiotic relationship with their own parents, it is CB policy that with rare exceptions children are not placed with grandparents.

Those few couples who are not suitable for group therapy, or who need additional help, are seen in couple therapy, which is seen primarily as an adjunct to group therapy, particularly in times of crisis when there simply is not enough time to work through problems. A few couples who are not suitable for a group, or who have refused group therapy, are seen by MH/MR staff in addition to the caseworkers' contacts.

Group Therapy

The psychotherapy of choice in this program is group therapy. Somewhat fewer than half of the families in the two abuse units participate in the group therapy program. Criteria for exclusion of clients include the following: inadequate intellectual resources to participate in and benefit from a dialogue with others or to see the possibility of alternatives; strong resistance which takes the form of extreme hostility, baiting others, and/or sabotaging the group by monopolizing its time with diatribes about how the person shouldn't be there; and acute psychosis. Groups are open ended so that a couple can join at any time. It is not uncommon for a couple or an individual to leave the group for 6 months to a year after a period of involvement and then to return once again for another year. Some couples have come because they are court-ordered and, while everyone agrees that voluntary participation is better, several of the court-ordered couples have become very involved in the treatment process.

The task of preparing an individual or couple for referral to the MH/MR treatment program belongs to the caseworker. The caseworkers deal with initial resistance and anxieties and explain the group process to the potential new member(s). Following this initial phase, potential new members are seen by one of the group's co-therapists for an interview. Generally, psychological assessment is done only after initiation into the group, as the experience has been that too many intake demands only serve to heighten the resistance of new clients.

Each of the three groups meets once a week for 1 to 1½ hours and each has approximately six to eight members. The membership of the groups is mixed in that it includes couples as well as single parents. While the single parents tend to be women, either partner in a couple may, for awhile, attend without his/her spouse. In the case of psychological couples, attempts are made to involve boyfriends although there is some concern that this may serve to cement negative relationships which might otherwise not be cemented.

Each group has four therapists: two co-leaders and two caseworkers, one from each county since families cross county lines to be in the group of their choice. The group co-leaders take major responsibility for the groups, but all

four professionals take turns confronting, supporting, mediating, and integrating.

Because the CB caseworker is most often the one who brings up information from the previous week with which the client may not wish to deal, the caseworkers are likely to engender considerable hostility. Care is taken to ensure that all professionals do their share of confronting, lest the negative feelings toward any one professional become so strong as to disrupt either the group process or the individual client/caseworker relationship.

Professionals share their feelings with the group if the feelings are reactive to what someone in the group is doing or feeling. Professionals do not share their problems or unrelated feelings with the group.

Group members discuss their problems or the week's difficulties and others relate their own experiences to these problems, either spontaneously or in response to a question from one of the professionals. A single theme is sometimes, but not usually, pursued. Thus, clients tend to take turns, each person or couple bringing up a problem and then generating some related discussion. Continuity from week to week is not usual unless everyone has agreed in the previous week to discuss a particular issue in the next session.

The Northampton County group, which meets in the CB building so that the children are in the next room playing with three volunteer college students, has joint sessions between parents and children approximately every 6 weeks. In these sessions, professionals play with the children, parents are encouraged to join in, and the emphasis is on modeling more comfortable and adaptive parent-child relationships. For instance, at Christmas, one of the group's fathers dressed up as Santa Claus and distributed presents to all the children who took turns sitting in his lap.

The process of the groups is described as psychoeducational in that it combines a psychotherapeutic and an educational approach. The life of any given member in the group is characterized by four broad stages: the stage of resistance and mistrust, the stage in which a working relationship is established, the stage of working through and of assisting others in the group, and the final stage of termination and followup. Average tenure in the group is approximately 1 year, although some have been members for nearly 3 years.

Clients are encouraged to socialize with each other outside of the group meetings and in some cases do provide each other with a great deal of support. This aspect of the group is aimed at reducing the social isolation of the clients.

While most group sessions involve discussion of problems that clients bring up, some special techniques are occasionally used. Both role playing and specific assignments for what is to be done in the days following the session are sometimes used.

Following the sessions, one of the groups has an opportunity to meet without leaders and to discuss whatever they want. The purpose of this is to allow clients a time for debriefing without the intervention of the therapists.

Criteria for termination, not only from the group but from CB services, include: the ability to see some worth in the child; awareness of the child's dependent status; signs of some pleasure in the child; acceptance of responsibility for the child's well-being; awareness of the fact that small children are unable to nurture their parents; relief from situational stress; willingness to seek help and assistance; ability to express feelings, to take a place in society, to establish an adequate self-image; ability to have male-female adult relationships, and to differentiate and establish a family system which is separate from the extended family. It is reported that CB services continue at a reduced level for approximately 6 months after improvements are seen in order to ensure that the gains are maintained. The availability of staff, at any time that the parent feels unable to cope with a given child, is repeatedly stressed and parents are told both during ongoing treatment and at termination, "... the time may come when you will feel like hurting this child. Don't do it—call us and we will help you."

The cases which follow are intended to illustrate the treatment style and philosophy of the program:

Belle and Arnie

Belle and Arnie's child Joseph was first referred to CB by a pediatrician. Joseph had come into the hospital with extensive injuries; skeletal x-rays showed many different fractures in various stages of healing. The parents' response to the pediatrician's concern was a third-party accusation involving a caretaker. The caseworker became involved in the case after 3 weeks in

intake and was involved in a series of community interviews around the credibility of the caretaker. It was established that the caretaker was not responsible. Since it was decided that Joseph would have to be placed in foster care upon his release from the hospital and since the parents refused to put the child in placement, CB filed a petition to the court requesting placement. Following several court appearances which required extensive preparation, the court agreed to keep Joseph in placement.

Belle and Arnie came to the group and initially only wanted to convince the group of their innocence. The group was able to deal with this and point out the level of responsibility to the child regardless of their role in the abuse. In addition, the caseworker redefined the contract with Belle and Arnie away from guilt v. innocence to more effective nurturance and parenting. Following this restatement of the issue, the parents began to see the caseworker and the group as friends and allies.

As the positive therapeutic alliance between the caseworker and the couple developed, Belle and Arnie began to discuss some of the acute tensions in their lives. Arnie felt controlled by his authoritarian father who had never given him much affection but who expected obedience and acquiescence. Belle felt unaccepted and put down by her father-in-law, but other than to complain about him at moments of anger, she and Arnie never discussed how both of them felt controlled and manipulated by Arnie's father. For the first time, Belle and Arnie began to discuss these feelings and to support each other so that eventually Arnie was able to confront his father with his feelings.

Similarly, they began to deal with their own relationship and the fact that Belle, who needed and looked for a great deal of support, got very little from Arnie. He became aware of his lack of assistance in terms of child care and grew more sensitive to her needs.

Joseph, who was returned after 4 months, did very well upon his return. During sessions with the family in their home, he was generally present and the caseworker would casually play with him and model things that the parents could do. As Arnie became more involved in the care of his son, he began to see him as more of a person and to derive much more pleasure from him.

Following the final hearing, the family chose to terminate but did come for a series of followup sessions to the group and with the caseworker. A 6-month followup visit showed that the family was still doing well.

Alice

Alice, a woman in her early twenties, had been known to CB since she was a little girl. She grew up in foster homes and institutions, was known to the police and probation, and had early psychiatric problems including suicide attempts. She has had one child in foster care since birth and has a toddler at home. Alice has an explosive temper, is frequently enraged and involved in battles with her neighbors, and is desperately attached to and dependent on her little girl, whom she perceives as her only source of gratification. Initially her sole companion, she was the constant brunt of her temper outbursts and frustrations with other people. Moreover, she was so controlling with her that she was quite unable to allow her to play, feeling that she did not use her toys properly and was too messy.

Intensive casework, group therapy, and the Home Start program have produced considerable change. The caseworker and the group have continued to confront Alice about her harshness with the child and her inability to allow any separation. Eventually, Alice was able to allow her participation in day care. She has become willing to try what the Home Start visitor does, but this has to be handled with great delicacy lest she abuse her daughter for not completing Home Start set tasks. Fortunately, the level of coordination between Home Start, CB, and MH/MR is so good that the Home Start visitor is attuned to the possibility that Alice could perceive her games as a series of tests for the child.

Recently, following an angry outburst, Alice became abusive toward her daughter but stopped herself and called CB for help. She was given some very specific directions as to what to do and was able to follow them to the letter. When she told the story to the group, one of the members began to say that she was slipping back to the old abuse days; Alice was able to defend herself and point out the differences. She made it clear that this was an isolated incident which she disliked and sought to control, following a period of playing, and a positive relationship which was quite different from the past where she never played with the child and only experienced her needs as unreasonable.

Hilary and Harry

This couple has five children, the older three are from Harry's first marriage. Currently, all five children are in foster care as the mother has at various times abused and been unable to relate to all five of them. The three older children are 9, 10, and 11 years old, which is older than most children served in the abuse program. The elder daughter is being seen by a child psychiatrist at the MH/MR.

Therapy with this couple, which takes place in one of the groups, is centered around trying to make Hilary and Harry responsive to each other's needs. She tends to be chronically depressed, whiney, and demanding and he has been unable to respond to her. Initially, he felt that as long as he kept a job and supported his family he had fulfilled his marital and paternal responsibilities. He was mistrustful of Hilary's fidelity and rather insistent that she remain at home. She felt stifled in a state of total isolation and deprived of adult company.

Initially, she monopolized the group sessions and complained about her husband while he made statements to the effect that he was not interested in her complaints.

After 5 months in the group, Harry has become much more supportive of his wife and more helpful. He has been able to allow her the enjoyment of her own part-time job and has been less likely to work overtime and ignore her.

Hilary's mother is a very domineering, intrusive woman. Recently with the support of the group, Hilary has been able to set limits on her mother's intrusiveness.

Currently, there has been sufficient improvement that three of the children are being slowly reintroduced into the home. The three children have been spending weekends with their parents and it is reported that Hilary and Harry are more sensitive to each other's and to the children's needs.

Individual Casework

The following case illustrates the enormous difficulties sometimes involved in working with resistive families and in validating cases in the face of persistent parental denial. It also illustrates a growing knowledge of how to approach such situations in terms of approaching the parents on the issue of the difficulties they are having with the child rather than on abuse.

Marjorie

Marjorie and her husband have three children, the youngest of whom is now 6 years old. This youngest child, Shirley, was first referred to CB when she was 4 weeks old by a physician who filled out a CY-47 because she suffered from first and second degree burns over various parts of her body. She also had several hematomas and abrasions. The parents claimed the injuries were an accident and refused contact. The case was eventually closed.

When Shirley was 4 years of age, she was referred by a relative who suspected abuse but had no evidence. The family refused to work with CB without a court order and the relative refused to testify. Once again, the case was closed.

When Shirley was 6, she was referred by the elementary school which filed a CY-47. The child reported being hit by the mother who denied this and said the bruise was from an accident. The school reported that the child is retarded and emotionally deprived.

A worker in the new abuse unit began to work with the family asking them to talk about their views of this child. The father described her as demanding, obnoxious, and having a terrible temper. The mother also discussed her difficulties with the child and her dislike of her. The worker introduced the mother to Parent Effectiveness Training; the mother has become involved in working with Shirley and now sees the worker as a helpful person who is addressing her problems.

The following case also illustrates the handling of initial resistance and the case manager role of the caseworker in terms of introducing a variety of services to a family and ensuring that the services continue to be used.

Molly

Molly and her husband have two children: Don, age 2, and Donna, age 10 months. Donna was referred as a young infant; she had been a premature child, weighing 3 pounds at birth. In the ensuing 4 months she gained a total of 3 ounces and was referred to the hospital by the family pediatrician who filled out a CY-47. The child was brought naked to the hospital in 30° weather and was diagnosed as suffering from severe malnourishment. The baby gained weight in the hospital and the CB worker began his contact with the family in the hospital.

The worker set up a program with the family in which it was agreed that the pediatrician would see the family every 2 weeks, a visiting nurse would come weekly, and that Home Start would also make weekly visits since the mother had also identified the older child as a problem. The father was resistant to Home Start, but the worker stated firmly that he wanted them to try it and see for themselves if it was helpful.

At this point, all of the above services are in place and the CB worker sees the couple two times a month to help them focus on their problems with each other and with their extended family. They are beginning to listen to each other and to respond to each other's needs and the children are reported to be doing well.

THE SERVICE DELIVERY SYSTEM

This section provides a description of two additional components of the child abuse program: Home Start and the Lehigh University Center for Social Research.

Home Start is a special option to a Head Start program and is designed to teach parents to teach their children. Instruction is provided in the family's home on a weekly basis by a specially trained Home Start educator. Begun in order to service families in rural areas whose children might not otherwise have the advantages of a preschool program, the Home Start program in this region is now in its second year. Abusive families were not originally a focus of the program.

In October of 1974, the Home Start supervisor hired two educators, one for each county, and began visiting those families referred by CB. While the home educators can each work with 15 families, each is presently serving 11 families.

The visits made to abusive Home Start families are not unlike those made to other Home Start families. They consist of planned activities based on the curriculum developed for the child and mother. The parent is taught to help the child with the task, the educator explains the importance of the task, what skills it is designed to build, and what level of skill the parent can expect the child to exhibit. In addition, the educator spends time talking to the mother about any difficulties she may be having either with her child or her family, or any areas she may wish to discuss with another adult. The real difference between the ongoing Home Start program and the program for abusive families is in the area of service coordination. While the special Home Start workers receive guidance from their supervisor, they are also in very close contact with the CB caseworkers. If the Home Start visitor learns of a new situation developing in the client's home or of a new service need, this information is relayed to the family's CB worker. Similarly, CB workers inform the Home Start visitors of such occurrences. This flow of communication is vital to a coordinated service delivery system as, very often, due to the way in which a family may perceive one or another worker, the Home Start and CB workers do not receive the same information from the client. While a mother may feel comfortable discussing a particular issue with the Home Start visitor, she may not mention it to her caseworker, or vice versa. Thus, in order to obtain a complete picture of the family, both workers speak to each other several times each week and both attend the monthly case staffings. At present, in order to further enhance communication, plans are being made to have the Home Start visitors observe group therapy sessions and to be part of each county's CB special unit supervisory meeting.

The professional staff of the Lehigh University Center for Social Research have been involved with the CB special units since the project's conceptualization and the development of a funding proposal. As such, the research unit is an integral part of the total program.

At the time of the site visit, research efforts were just beginning. A review of the relevant literature was underway, hypotheses grounded in the literature were being developed, and data collection instruments for use in assessing program effectiveness were being designed. The research team had spent a great deal of time with staff from each of the participating agencies helping them define and operationalize their objectives so that meaningful instruments could be developed.

The purposes of the research project are

- to design a coordinated recordkeeping system
- to assess the quality of parent-child interactions
- to assess changes in parents
- to assess children, both in groups and individually

- to prepare an expanded annotated bibliography
- to prepare a community census

In addition to these formal objectives, the research team is developing its materials in such a way as to permit their use in training both parents and agency staff. Thus, in order to assess parent-child interactions, the team is videotaping the mother and child as they perform a series of prescribed tasks. Interactions are then coded and the tape can be shown to mothers to make them more aware of the manner in which they relate to their children as well as shown to workers involved with the family who will be able to use it in determining those areas in which further help is needed. It is planned that several assessment areas will be videotaped so that training "records" will be developed.

COMMUNITY EDUCATION AND TRAINING SERVICE PROVIDERS

Until the current year when special funding was received, most of the staff energy has been invested in the development of a treatment program and in developing working relationships between the participating agencies. However, throughout this period, staffs of the MH/MR and of the CBs have given presentations at the local hospitals, have talked with school officials, and have talked with local community groups.

As part of the new funding, the coordinators in each county are engaged in considerable training and speaking efforts in the community. Already, neighboring counties have expressed an interest in setting up a similar CB/MH/MR program and they are being assisted in this process. There is every expectation that over the next 3 years, staff from this program will reach a very large number of service providers and community groups both in the demonstration and in the neighboring counties.

SUMMARY OF KEY FEATURES

The most unusual feature of this program is the level of coordination and joint therapy between the public agency with mandated responsibility for child abuse cases, Children's Bureau, and the mental health agency. Because of this strong collaborative relationship, this program represents an important model for public social service agency and mental health center cooperation. The social service agency is able to provide a broader repertoire of therapies to its clients and to provide quality training to its caseworkers who learn a great deal in their work as co-therapists to mental health staff. The mental health agency staff feels more comfortable and secure in working with the families because of the participation of the social service agency workers who provide the initial experience with abusive parents and who serve as a link between the family and a variety of concrete services.

Another unique aspect of this program is the cooperative relationship between the child welfare agency and Home Start. This effort represents an important attempt to work with the children and to counteract some of the negative effects of abuse and inadequate stimulation.

The highly developed group therapy program, the caseloads of less than 20 for staff in the abuse units, and the emphasis on intensive treatment are important features of this program.

Chapter IV — Community-Based Team Programs

INTRODUCTION

The two programs presented in this section represent community-based efforts aimed at better coordination of services and at increasing the capability of any one agency. Neither program receives any funding and both programs are located in relatively small communities in States in which most of the population lives in rural areas and in which no single agency has the full armamentarium of resources and consultants necessary to provide effective services to abusive and neglectful families. The public social service agencies lack the professional social work staff or the consultative services which would allow them to effectively carry out their responsibility under the law to deliver services. Understaffed and without adequate resources, the public agencies primarily conduct investigations, link families with resources, and respond to crisis situations. The development of sustained therapeutic relationships is really not possible in most instances. Both programs illustrate the difficulties in interagency relationships which have to be resolved before the team can begin to function effectively.

The Billings and Laramie teams represent marked differences in implementation. The Billings Team is designed as a community effort to provide consultation around case disposition; the team does not act as a treatment unit. The Laramie Council is designed primarily for the purpose of community education, whereas the treatment team acting as a unit provides treatment to families and reviews weekly what each member has done with each family.

The Laramie Program is noteworthy because it is only one of two programs visited (Lehigh-Northampton is the other) where the mental health center has taken an active responsibility for the development of a responsive treatment program.

The Billings Child Abuse and Neglect Community-Based Team Billings, Montana

by Monica Holmes, Ph.D., and Douglas Holmes, Ph.D.

Team Coordinator: Doris Olsen, MSW: St. Vincent's Hospital
Protective Services: Joseph Cahill

START-UP

In 1967, the Montana legislature passed legislation requiring that all abuse and neglect cases be reported both to the local department of welfare and to the county attorney's office. In 1970, the county attorney for Yellowstone County became involved in a case of child abuse which was known to the chief of social services at St. Vincent's Hospital (later to become the team coordinator) and to a pediatrician (later to become a team member). The family was known to several agencies but the county attorney experienced considerable difficulty in obtaining necessary information from the other agencies involved in this particular case. Frustrated by this lack of coordination among agencies and wanting to gain some specific knowledge about child abuse, the county attorney attended a training session in Denver at the suggestion of the hospital chief of social services. Following this session, the county attorney, the chief of social services, and the pediatrician joined together to form the nucleus of what was later to become the child abuse team. At this time, it was recognized that no single agency in the community had the resources and expertise necessary to deal effectively with all aspects of child abuse, and a team approach was planned as a solution to this problem. The county attorney took the lead in seeking to broaden the team. The team was established with considerable effort; concern about jurisdiction, about roles of various members and their agencies, about possible criticism over the handling of cases, all represented constraints to the formation of the team. Despite these obstacles, persistence of concerned professionals, most particularly of the county attorney and the future team coordinator, led to the formation of the team in February 1972. By the time of initiation, jurisdictional issues had been sufficiently resolved to permit participation of all relevant agencies, and St. Vincent's Hospital had agreed to provide space, including permission to maintain a central registry of cases detected in Yellowstone County. Since that time, the State Social and Rehabilitation Services (SRS), the agency to which the local county welfare department reports, as well as the Yellowstone County Welfare Department, have played a major role in providing support to the team and its approach.

While there is no clear legal statute which either permits or prohibits the functioning of the team, the legal basis for the operation of the team stems from the fact that the county attorney may, by Montana law, call upon any relevant agency to provide information relating to a specific case of abuse or neglect; the team is regarded, in this sense, as an "agency" designated by the county attorney to provide this information. In effect, the team is seen, legally, as a consultative body to the office of the county attorney.

As attested to by the continuity of team membership and by the regularity of participation in the weekly team meetings, the problems of start-up have been resolved, although it took approximately a year for the team to define its functions, chart a regular course of operation, establish collaborative relationships among members, and identify and clarify roles of team members. The need for a coordinator and the need for the weekly case presentation to be focused and to state specific questions were not immediately apparent, but became evident once the team was in operation.

The stages in the community team development have been carefully described in a paper prepared by Pete Surdock*, ACSW, which is

*Mr. Surdock is Assistant Chief of the Social Services Bureau, Community Service Division, Social and Rehabilitation Services, Montana.

quoted at some length. The first phase is characterized by

> . . . limited role clarification best exemplified in the conflict of who was ultimately responsible for the services to the abused and neglected family. Or to state it another way, "Can we trust each other?" The second stage of the team's development can be referred to as the building of trust or team "morale." This is seen in the team's ability to see themselves as a functioning consultative unit where opinions and observations can be stated and are accepted freely and the team identity emerges . . . The focus is on a coordinated effort with minimal concern for "territory or turf," but one of who can best do the job in this case or what part is played by whom. This does not require the SRS social worker to relinquish responsibility for the case. It does require the acceptance of a new role for SRS workers which is referred to as the "case management" role . . . . The third stage of development for the team can be referred to as the continuation not termination stage. This arrives after the team has achieved a groupness and realization of their effectiveness as a unit . . . .

The Billings team can be characterized as a well implemented community team in terms of the collaborative relationships among members.

PROGRAM OBJECTIVES

The objectives of the team are as follows:

- To provide expert consultation services to the county attorney so that he can make informed decisions as to whether or not cases will be prosecuted and what recommendations to make to the judge
- To provide consultation services to the department of public welfare in terms of recommendations for case management and disposition
- To serve as a coordinating mechanism for all agencies with an interest in child abuse and neglect
- To serve as a visible community resource for the handling of child abuse and neglect cases

Above all, it is the opinion of all team members that such a team is necessary because no single agency has the resources to cope with the problem.

PROGRAM AUSPICE

The team includes one, and in some cases two, representatives from each of the following agencies:

- county attorney's office
- department of public welfare
- St. Vincent's Hospital
- regional community mental health center
- health department

In addition, the team includes three community professionals who attend regularly: two pediatricians and a psychiatrist. However, none of these agencies constitute an auspice.

PROGRAM COSTS AND SOURCES OF FUNDING

The team receives no funding and expends no money: all of the team members volunteer their time. However, the Junior League of Billings, Inc., and the Montana chapter of the National Association of Social Workers did provide funds for printing a public information brochure about child abuse and neglect.

FACILITIES

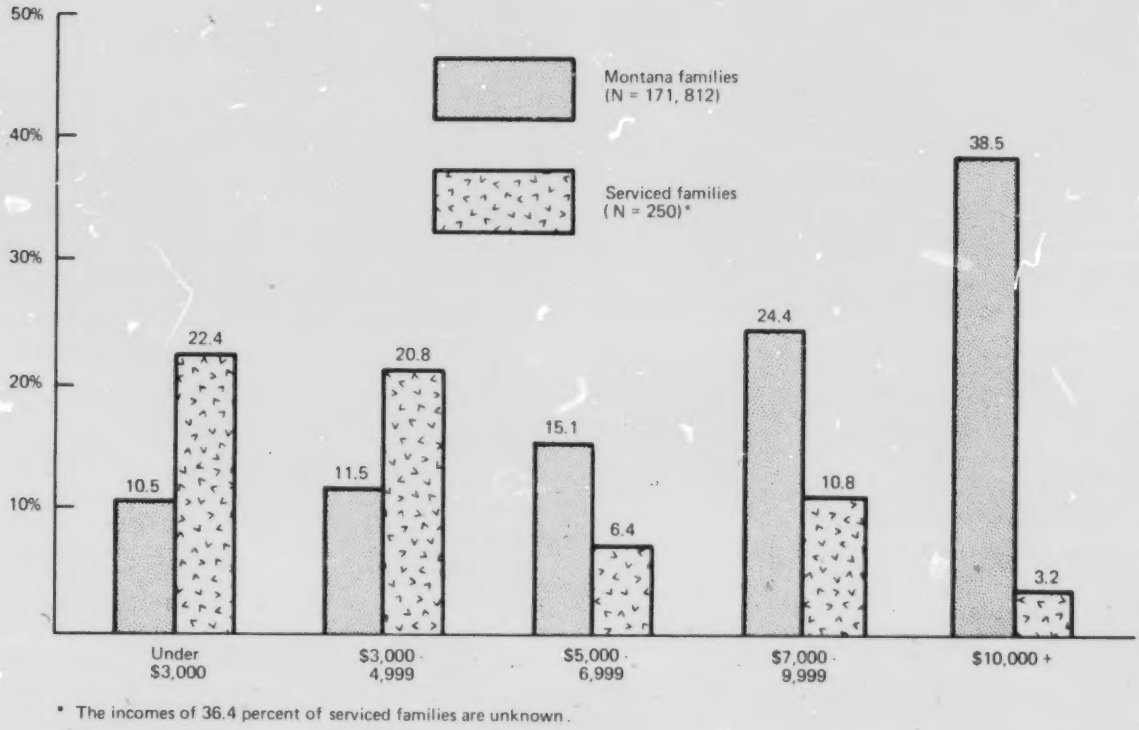
Team members use the facilities of their regular agencies and meet at St. Vincent's Hospital.

COMMUNITY AND PARTICIPANT CHARACTERISTICS

The population of Billings is 67,000. While SRS maintains extensive data based on cases in the entire State of Montana, a specific breakdown of the 42 validated cases in Yellowstone County is not available. Therefore, the data presented here are based on State rather than Yellowstone County characteristics. All data are based on the first 6 months of 1974.

SRS received validated reports on a total of 87 abusive and 163 neglectful families (123 abused and 283 neglected children). Approximately 41.7 percent of these cases are defined as recidivistic in the sense that the agency had previous records of abuse or neglect. While some were ongoing cases, the majority had already been closed prior to the new report. Approximately 11 percent of all client children were in placement in 1974.

As can be seen from figure 26, abusing and neglectful families are underrepresented in the



* The incomes of 36.4 percent of serviced families are unknown.

Figure 26. Income

higher-income groups. While 38.5 percent of the general population has incomes of $10,000 or more, only 3.2 percent of client families have such incomes. Similarly, while 24.4 percent of Montana families have incomes of $7,000-$10,000, this is true of only 10.8 percent of client families. Similarly, while 43.2 percent of the client families have incomes under $5,000, 22 percent of Montana families are in lower-income groups.

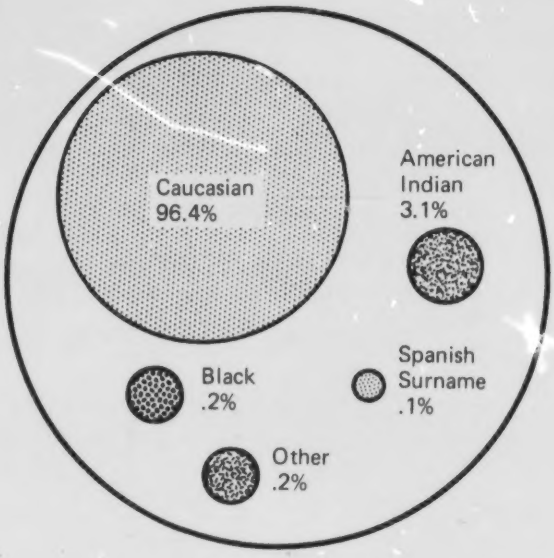
Figure 27 displays data on the ethnic status of Montana and client families. American Indians, who represent only 3.1 percent of the State's population, are overrepresented in the client group, as they comprise nearly 20 percent of client families. In general, other ethnic minority groups, i.e., Spanish-surname and black families are overrepresented in the client population. As these groups are generally overrepresented among low-income families, it is not surprising that ethnic minorities are overrepresented among client families.

Data on age distribution of children presented in figure 28 show that the largest single group of client children (33.5 percent) are 12 years of age and over, whereas children 0-3 represent the smallest client group (16.6 percent). This relatively small percentage of children 0-3 and the relatively high percentage of children 12 and over is likely to be directly related to the sources of client referral. In hospital-based programs the majority of children referred are three and under; however, only 7.4 percent of SRS referrals come from hospitals.

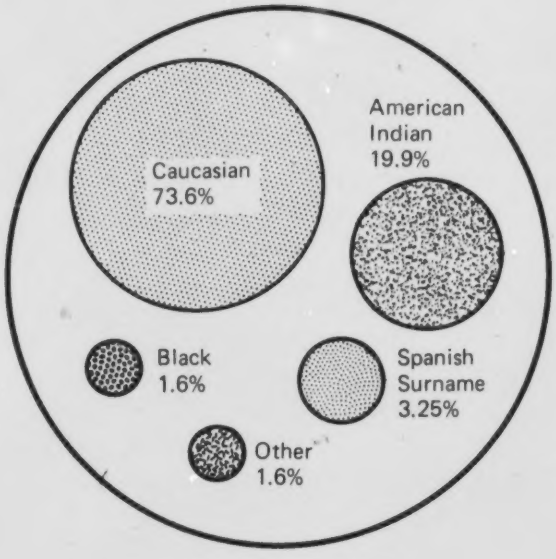
The sources of referral are presented below and, as can be seen from table 6, hospitals represent only a small proportion of all referrals.

Table 6. Sources of referral

Source	*Percent*
Neighbors	21.2
Law enforcement	17.2
Schools	15.8
Public social agencies	12.8
Relatives	12.8
Public health nurses	9.5
Hospitals	7.4
Other agencies	3.8
Total	100.5



Catchment area population



Serviced population

Figure 27. Ethnic status

THE TEAM IN OPERATION

The local department of welfare investigates each case in order to validate reports of abuse and neglect. The department's findings are reported to the county attorney who must make decisions as to whether or not to bring the case into civil or criminal court and what action recommendations to make. In civil court the choices include: request for investigative authority, temporary or permanent custody of the child, and participation in certain health and social service programs by the parents.

The team meeting is designed to provide consultative services to the county attorney regarding his recommendations and to the department of welfare regarding disposition and management. Most cases are brought to the attention of the team either by the county attorney or by the department of welfare. In some cases, the reporting source for a particular case, e.g., the hospital, may request the staffing of a case.

Team members are present at all meetings; sometimes other relevant individuals are present, e.g., police, teachers, or family physician. These individuals are part of the extended team.

The actual staffing conference starts with a brief presentation of the case and a statement as to the questions to be addressed by the team. Typically, these include questions about what recommendations to make to the county attorney, development of a case management plan insofar as the coordination of services is concerned, and a decision as to whether there is any additional information which needs to be collected. Any one case may be staffed one or more times; to date, no case has been staffed more than four times.

The team coordinator has developed and maintains a local registry of child abuse/neglect cases. By arrangement with the county attorney's office, the team coordinator receives a copy of each reporting form filed with the county attorney's office. The coordinator maintains a file of these forms which provide family identifying information, the nature of the offense, and the referral agency. Upon request from a qualified source, e.g., physician, health and welfare agency, etc., the coordinator will indicate that the family/child is listed in the registry and provide the identity of the referral agency, which can then be contacted for further information.

Approximately 75-80 percent of the cases reported to the department of welfare are staffed by the team.

The team serves as a consultative and coordinating mechanism; it does not serve a case management or treatment function. Case

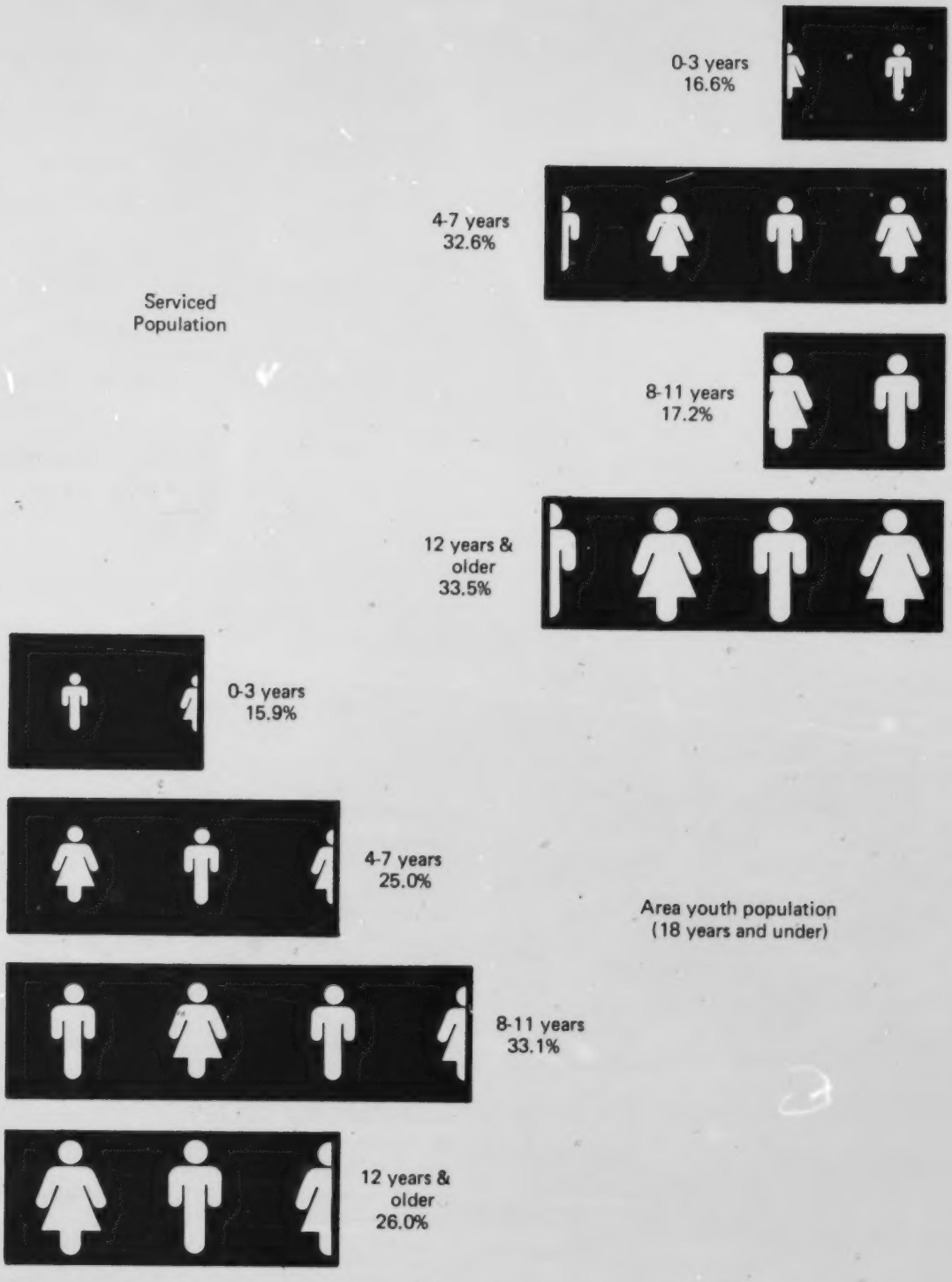


Figure 28. Number of youth in serviced and area populations

management or ongoing responsibility for service coordination and treatment are the responsibility of the department of welfare. Some clients are referred to the community mental health center for treatment.

TREATMENT

The great majority of families receive counseling services from protective services staff within the department of welfare. The protective services unit has one intake-crisis intervention worker, four workers, and one supervisor. None of these individuals has an MSW and they differ in the number of years of experience and the kinds of experience they have had. Moreover, the annual turnover rate is often more than 100 percent, as several workers may fill a single position in a single year.

The thrust of department of welfare services is to coordinate whatever other services can be obtained through other agencies and to provide short-term counseling which will help the family make some changes and get back to their pre-crisis level of functioning. If it appears that the child(ren) in a family are in immediate danger, they are removed and placed in foster care. Approximately 11 percent of all children reported are in foster care for an average period of 2 to 3 years. Children in foster care placements must be reviewed by a department of welfare supervisor every 6 months. The overall goal of treatment is the preservation of family unity.

It is estimated that approximately 50 percent of the cases are carried from 6 months to 1 year but some families are followed for less time and some have been known for as many as 4 years. Virtually all sessions are conducted in the home. Criteria for improvement include willingness to accept the department of welfare worker, improved home management capability, improvement in the children's appearance, and in the case of older children, the ability of family members to at least tolerate one another.

Contact with the majority of those families which are not in crisis ranges from once every month to once every 2 months. Staff would like to see families more often but crises interfere with more frequent contacts. Children in foster care are supposed to be seen once a month, but often are seen only once every 2 months. Once the immediate crisis is resolved and the child is determined to be not in danger, the case is closed with no further followup.

Department of welfare staff identified constraints to service delivery which include the following: inadequate services at the county level, lack of money for consultative and support services except in those cases where such services are ordered by the courts, large caseloads, staff inexperience and turnover, the difficulties inherent in establishing a relationship with multiproblem and sometimes hostile families. The caseload of each worker is between 40 and 50 families.

Treatment in most cases involves coordination of services and one-to-one contact between the mother and the worker. In the case of older children, some are seen in treatment and, in a few cases, older children are seen with their mothers or husband-wife couples are seen together. One of the staff does some work with children at the Receiving Home one afternoon a week. These are children who are awaiting foster care placement or possible return home following department of welfare investigation.

At present there are no groups and no younger children in treatment within the agency.

The following case example illustrates the conjoint counseling that some workers do in the case of older adolescents. The emphasis is very much on reality and what specific changes need to be made in order to achieve some modus vivendi for all concerned.

Brenda

Brenda is a 14-year-old girl who was continually running away from home and was very hostile to adults. She was placed in the Receiving Home and then refused to go home to her mother. The worker got the girl involved in a hobby-crafts group at the "Y" and began to see the girl with her mother once a week. These contacts continued for 7 months. The mother and daughter, who had refused to have anything to do with one another, began to speak to each other. The mother was able to see that she was extremely critical of Brenda, that she continually put her down, and was overly strict. At the same time, the girl began to make her needs known to her mother in a more reasonable and acceptable manner.

The following case illustrates the crisis nature of many of the cases:

Bella

Bella reported to the department of welfare that her 9-month-old baby had been kidnapped by his father. The baby was under treatment for a severe ear infection. The parents had been separated but had decided to try getting back together again. Finally, the child was located in a hospital in Portland with 105° fever and meningitis. The department of welfare sent Bella to Portland so that she could be with her baby; when Bella and the baby returned, the department found an apartment for them. The father was referred for treatment at the community mental health center but did not go. Ultimately, Bella was helped to join her parents in Missouri.

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The Comprehensive Community Mental Health Center receives the greatest proportion of its support from the National Institute of Mental Health. The center is staffed by 1 psychiatrist/administrator, 4.5 social workers, 9 psychologists (of whom 5 are at the Ph.D. level), and 3 psychiatric nurses. No specific differentiation is made between cases of child abuse and neglect and other cases coming to the mental health center. Abuse/neglect is seen as only one manifestation of underlying emotional problems. Although the center might be characterized as providing primarily behavior-oriented therapy, diagnostic emphasis is placed upon underlying disorder rather than on any categorization by behavioral manifestations such as abuse and neglect.

A staff member of the center is represented on the child abuse/neglect team. However, mental health center staff frequently do not submit reports of suspected abuse/neglect to either the department of welfare or the county attorney's office as required by law, feeling that such report would seriously jeopardize the therapeutic relationship. Such reports are made only if it is felt that there is imminent danger of physical injury to the target child or if the therapeutic contact is, in effect, terminated by the client without successful resolution of the problem. It is estimated that of the approximate 25 to 30 cases known to the center per year which involve child abuse and neglect, only an approximate 12-15 are actually reported to either the department of welfare or the county attorney. Following are the mental health services provided by the center:

Initial Screening/Evaluation

At the time of intake, a general, casework-type screening is provided for all clients. Additional screening, including psychiatric evaluation, psychological evaluation, and medical diagnosis, is provided as indicated.

Psychotherapy/Counseling

The center regularly provides individual psychotherapy, couple therapy, a children's therapeutic nursery group, and mothers' groups.

Therapeutic emphasis is upon reality-oriented therapy and upon behavior modification, specifically. Case assignment, and thus the therapeutic modality, is a function of the individual conducting intake who is most likely to then become the treating person. Cases are not discussed prior to assignment to a particular therapist, and treatment modality for a particular case is determined by the therapist. Treatment is short term, with a majority of cases being terminated within 3 months and almost all within 6 months. It is felt that cases involving child abuse take longer than other cases, i.e., at the 6-month end of the continuum. There are no long-term treatment services available at the agency.

In addition to the treatment modalities noted above which are provided by a variety of different individuals representing several different disciplines, the center also provides a day care program which is primarily a behavior therapy program for hyperactive children. This program is directed by a psychologist specializing in early child development and is provided for two groups of children, 4 days a week each: 3- and 4-year-olds meet in the morning, while 4- to 6-year-olds meet in the afternoon. There are eight children in each of the two groups.

There are also two therapy groups for children which meet once a week: one for children 8-10 years old and one for children 13-15 years old. As in the other groups, emphasis in these groups is upon behavior therapy.

An adult day treatment center is also operated by the mental health center for two groups of patients: one for the chronically ill, and one for the acutely ill. Emphasis among the chronically ill is maintenance, i.e., postponing or obviating the need for hospitalization; among the acute

patients, the therapeutic regime usually extends for between 3-6 months and again involves emphasis upon socialization and behavior modification.

The center is just beginning to develop a formal, written treatment plan for each client. Particularly through a new research project, an effort is being made to develop a specific plan for each client in terms of a series of manifest treatment goals. Achievement of each of these goals is recorded and, if indicated, discussed with the patient. At times, working with the patients, the entire plan may be revised, extended, etc.

Center staff has received little, if any, training dealing specifically with child abuse and neglect. This is both reflective of, and contributing toward, the practice of the center *not* treating abuse/neglect cases differently from other cases coming to the center's attention. The center has no outreach capability and patients who are unmotivated or who skip appointments are not called or actively pursued.

THE SERVICE DELIVERY SYSTEM

All of the individuals interviewed who belong to the team, the coordinator, the two pediatricians, the psychiatrist, department of welfare staff, the mental health center representative, the county attorney, the public health nurse, feel that the team has made a great contribution in terms of agency education, consultation, coordination, and support to the department of welfare staff who take responsibility for case management. As everyone pointed out, exposure to different points of view, availability of psychiatric opinion as to the need for further evaluation and the issues to be considered, availability of legal advice, and general exchange of information are all extremely helpful. Several team members would like to see the team sponsor a lay therapist, a parent aide, or a parents anonymous program. Several agencies are clearly interested in having the team develop a treatment capability.

The team has served to focus interest and awareness of child abuse and neglect in a number of agencies. The police department, for instance, has two officers assigned to child abuse and neglect, both of whom have been to the Denver program for training. The police department feels that not only are they more attuned to abuse and neglect, but that they are also aware of the need for coordination with other agencies and feel that their relationships with other agencies have improved considerably.

Some individual team members have had impact on the agencies which they represent. For instance, the team coordinator, in her capacity as director of social services at St. Vincent's Hospital, has conducted training sessions for emergency room staff and on identification for nurses in maternity. Using a checklist developed by the team, maternity staff are encouraged to identify high-risk women who they think will experience difficulties in child care. Such cases are then followed by a public health nurse throughout the child's infancy to ensure adequate care of the baby.

COMMUNITY EDUCATION

Various team members have given talks to local civic, church, and PTA groups. The informational brochure, entitled *Help*, is reported to have been given wide distribution throughout the community.

SUMMARY OF KEY FEATURES

The Billings program illustrates the possibility of overcoming jurisdictional problems in the development of a team approach. A team in which all members act as consultants to those who are required to make decisions or to deliver services in a city in which agencies are relatively small and lack the resources of comparable agencies in larger metropolitan areas is an effective way of overcoming the lack of resources. While this type of team does not address the need of many families for a long-term supportive relationship and does not increase the level of services available, it does serve as a first step in mobilizing community agencies to deal with the problems of abuse and neglect.

Laramie Child Abuse Council and Treatment Team Laramie, Wyoming

by Monica Holmes, Ph.D., and Douglas Holmes, Ph.D.

Treatment Team Coordinator: William Edwards, Ed.D.,
Southeast Wyoming Mental Health Center

START-UP

The antecedents of the Laramie Program lie in the death, from a severe beating, of a Head Start child in the summer of 1970. The abusive family had been known to virtually every agency in Laramie during the previous 5 years; both children in the family had been reported to the department of public assistance because they were chained in the back yard and had been seen eating out of garbage cans. They were known to the public health agency, to Head Start, and to the community mental health center. In 1970, however, there was still no concept of a team approach, and the death of the child served primarily to heighten institutional defensiveness and denial of responsibility.

In the summer of 1971, another Head Start child with cigarette burns on the scalp and bruises over his kidneys was reported to the police. No agency action was taken and within 2 weeks the child was reinjured. Before any action could be taken, the family moved away. They returned in the summer of 1972, and it became evident to Head Start staff that the child was severely disturbed and withdrawn.

Following the severe damage to this second child, the Head Start nurse, now a teacher at the School of Nursing of the University of Wyoming in Laramie, contacted a professor in the University Law School; together they initiated the Laramie program.

The first result of this activity was the creation of the Wyoming Child Protection Center. Because the State of Wyoming has no medical school this was located within the College of Law. The center is intended to serve as a clearinghouse for information within an academic setting and to provide therapeutic, educational, and research services. The center received minimum funding from LEAA for 1 year, which was used to hire a half-time coordinator; it has not received further funding and is therefore still in the conceptualization phase. The center did assist in the setting up of teams throughout Wyoming, so that currently there are teams (either planned or implemented) in 22 of the State's 23 counties. The center has developed a project advisory committee which includes representatives from social work, child development, and psychology. It is hoped that this committee will be able to secure funding and provide leadership for the center.

The program began as an undifferentiated Council-Treatment team. At the first meeting in July 1972, the problem of the "agency run around" and the need for service coordination were discussed. The independent, and thus limited, functioning of all of the agencies was highlighted. Participants at the first meeting included representatives from the law school, the police department, the Department of Public Assistance and Social Services, public health, the mental health center, the Laramie public schools, family planning, the college of nursing, the Council for Exceptional Children, and Head Start.

By February 1973, the decision was made to separate the treatment team and council functions, and the first meeting of the Treatment Team was held. Initially, the Team was composed only of a representative from the Child Protection Center, the mental health center, the Department of Public Assistance, and a private attorney. The Team met once a month and had very few cases to discuss. Reportedly, many "turf problems" developed between the legally mandated Department of Public Assistance (D-PASS) and the other representatives. The Team was seen primarily as a "vigilante group," providing a forum for the criticism of D-PASS handling of cases. Eventually, in May 1973, the Team expanded to include representatives from public health, family planning, Head Start, mental health, the public schools, and a child development center which serves retarded

and handicapped children. At that time, the Team began to meet weekly and there was some evidence of improved interagency relationships and coordination. Issues regarding the authority of the Team to discuss cases, the nature of cases which would or would not be referred by the Department of Public Assistance (D-PASS) to the Team, and the benefits of a team approach were seriously questioned. The police department gave particular impetus to the development of a multidisciplinary approach and highlighted the limitations of any one agency by reporting all suspected and potential abuse and neglect cases to the Team, as well as to the mandated public agency.

Another factor which gave impetus to the continuation of a multidisciplinary approach was the cohesiveness and interest developed by the nonmandated agencies and their determination to continue as a team, if necessary, without the support of the mandated agency.

Following creation of the Treatment Team, the founders of the center within the law school turned their attention to the development of the Council. In January 1974, a minister in the community assumed leadership of the Child Abuse Council of which the Team was conceptualized as the treatment arm. The Council is seen as a citizen's group which promotes public education about child abuse, reviews and tries to have an impact on legislation, identifies gaps in services and works for their development, and represents the public interest in terms of seeking public accountability from community agencies. At present, the Council meets monthly and is developing a set of bylaws as a first step in applying for corporate status.

The organizational chart, figure 29, demonstrates what is anticipated for the future. At present, only the Council and its Treatment Team are implemented and these represent the subject matter of this program case study.

PROGRAM OBJECTIVES

The objectives of the Laramie Council and the Treatment Team must be viewed separately.

- *The Council*
  The objectives of the Council are to serve as a policy-making group which can look at various aspects of child abuse in the community. Community education, public accountability of public agencies, and stimulating the creation of new and responsive services are the central objectives of the Council.
- *The Treatment Team*
  Conceived as the treatment arm of the Council, the objectives of the Treatment Team center around diagnosis, case management through service coordination, and treatment.

PROGRAM AUSPICE

Neither the Council nor the Treatment Team have any auspice under which they function. The Council is currently seeking incorporation as a private nonprofit agency; once this is obtained, the plan is for the Team to function as the treatment arm of the Council.

Team members report that there is no agency in the community which could become the host agency for a child abuse and neglect program. The hospital has no resident staff, which is seen as a major obstacle to the creation of a program within the hospital. D-PASS has no social workers with an MSW, so that it is felt that even though they are the mandated agency for providing services, they lack the expertise and professional training with which to operate a comprehensive treatment program.

PROGRAM COSTS AND SOURCES OF FUNDING

Both the Council and the Team function on a voluntary basis; they receive and expend no monies. Consideration is being given to seeking some financial support because it has become evident that community education and training materials would be desirable. In addition, as the Council is beginning to seek accountability from the Team, the need for some data gathering has become manifest; the Council would like to hire a part-time data coordinator.

FACILITIES

The Team uses the facilities of D-PASS or of the mental health center for its meetings and the Council uses a meeting room at the University Common Ministry. Individual Team members use the facilities of their various agencies; the Council or Team as such have no facilities.

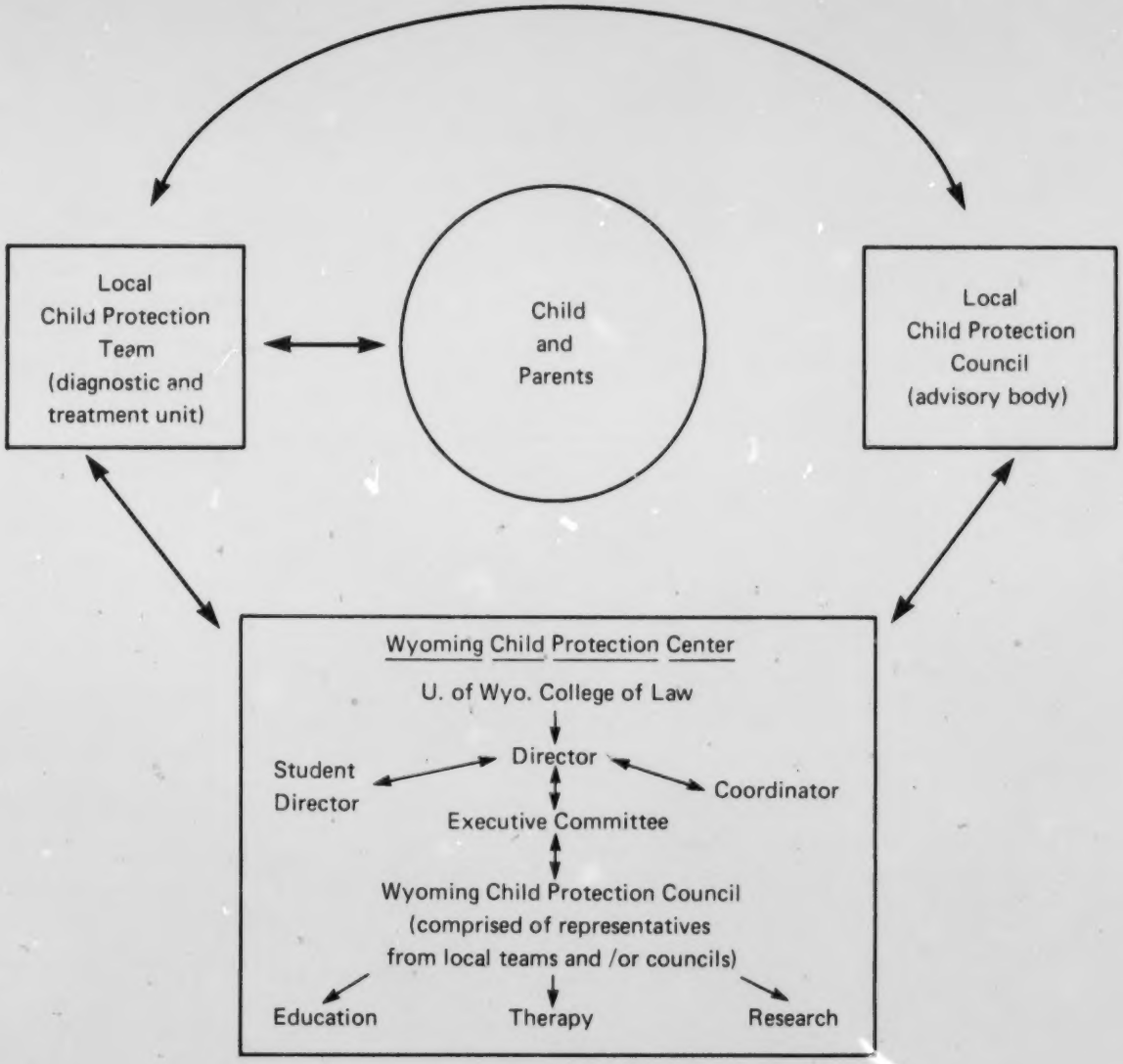


Figure 29. Proposed organization and function of child protective services in Wyoming.

COMMUNITY AND PARTICIPANT CHARACTERISTICS

No data are available on the characteristics of families which have been serviced by the Team. Such information is not recorded on individuals and therefore could not be tabulated.

All of the agencies involved report that abuse is rare and that most cases involve severe neglect. Because there is no physician involvement on the Team and therefore no child abuse training for the physicians in the community, it is impossible to determine how many abuse injuries go undetected or are overlooked and not reported as abuse.

Albany County can be characterized as rural with approximately 4,248 square miles and a population of 26,431. There are approximately 8,007 households in this area, with an average household size of 3.3.

As can be seen from figure 30, 11.8 percent of the families have incomes under $3,000 and an additional 11.9 percent of the families have incomes in the $3,000-$5,000 range. Thus,

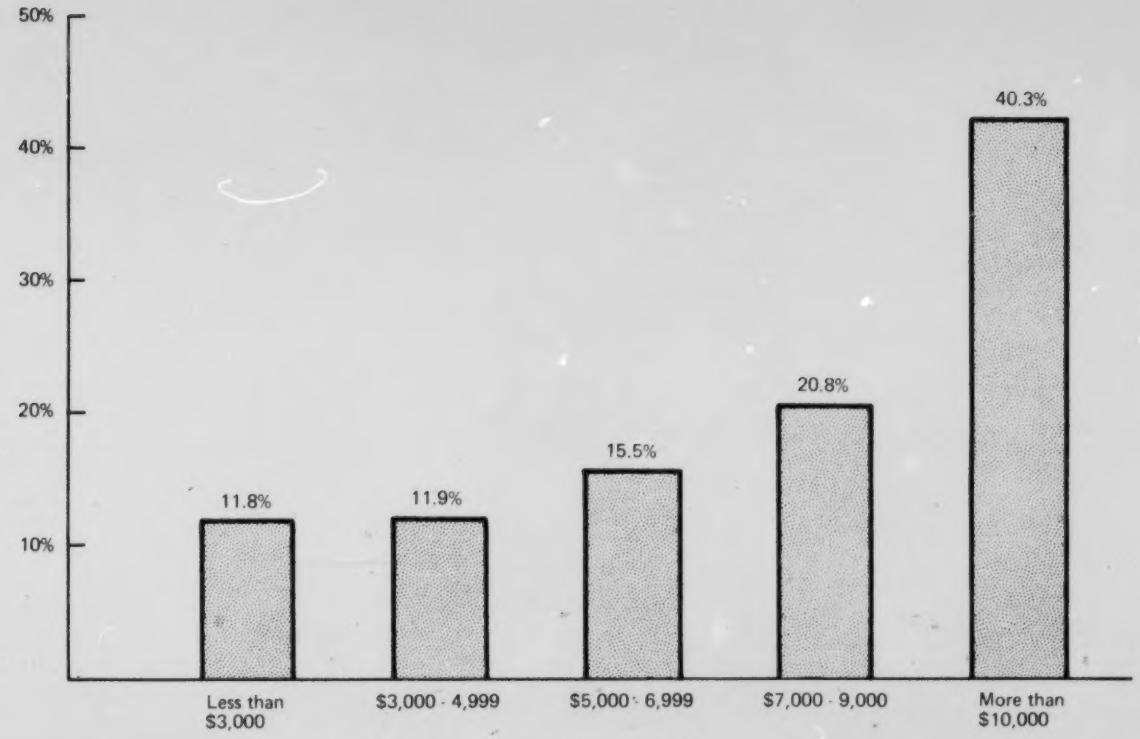


Figure 30. Income of families in Albany County

nearly 23 percent of the families in the county have incomes of less than $5,000 for an average family of between three and four individuals.

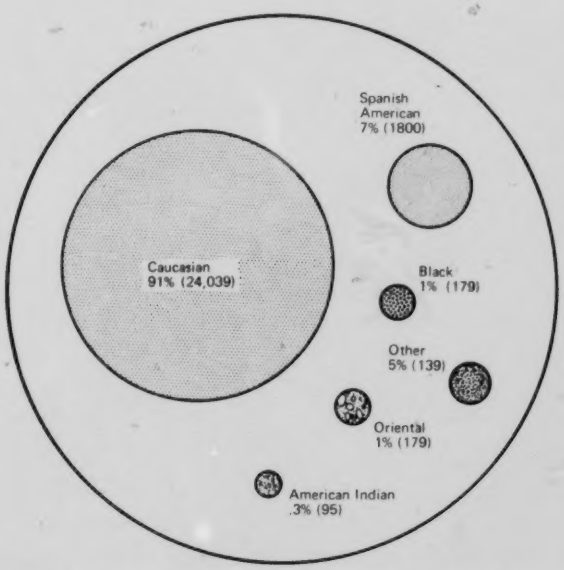


Figure 31. Ethnic characteristics of families in Albany County

As seen in figure 31, 91 percent of the families in the catchment area are caucasian, with the second largest ethnic group being those persons with a Spanish surname (7 percent).

Children under 19 account for 35.3 percent of the total catchment area population. As shown in figure 32, children under 10 years of age represent the largest age group of children in the county. Children under 10 represent 16.7 percent of all individuals in the county and 44.7 percent of all individuals 19 and younger.

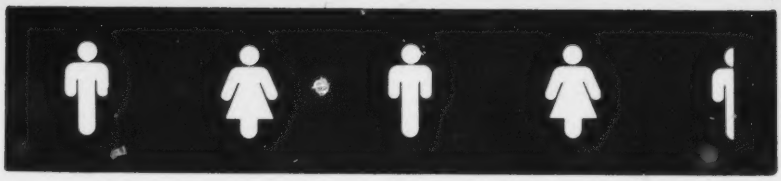
COMPOSITION OF COUNCIL AND TEAM

The Council has a fluid membership which ranges from 6-30 attendees at any particular monthly meeting.

The Treatment Team has a stable membership which, in addition to a lawyer who attends as a community professional, consists of one to three representatives from each of the following agencies.

Under 10 years old:
4,410 persons

44.7% of population 19 years old and younger



10-15 years old:
2,312 persons

23.4% of population 19 years old and younger

16-19 years old:
3,155 persons

31.9% of population 19 years old and younger

One figure represents 10 percent of given population.

Figure 32. The number of children in Albany County

- D-PASS
- public health
- mental health center
- Head Start
- elementary schools
- family planning
- child development center for preschool children

The Team has no staff as such; the psychologist from the mental health center serves as the team coordinator.

Throughout its 2-year history, the Team has been unable to involve any physician from the community in its operations. However, it is reported that since the site visit the two pediatricians have begun to show interest in the Team and have indicated willingness to act as consultants.

SERVICES AVAILABLE

Available services are those which are provided by the individual member agencies. The Team seeks to coordinate agency activities, to provide all agencies which may be involved in a case with relevant information, to mobilize the resources of individual member agencies, and to ensure that the planned services are actually being delivered. At each Team meeting there is generally a review of any new abuse or neglect cases followed by a brief review of all other cases known to the Team. New cases are brought to the attention of the Team by member agencies, which make their mandated report to D-PASS and voluntary report to the Treatment Team. In addition, the Team coordinator checks with the police each week in order to determine whether they have learned of any new cases.

Because the Team meeting generally includes a status review of all cases known to the Team, there is little opportunity to bring in other professionals who may have an interest in, or specific working knowledge of, any single case. The Team is aware of, and coordinates, services to approximately 20-25 families at any given time. The level of service coordination is high and management of cases is discussed not only at weekly Team meetings, but informally by various Team members in between meetings. For instance, the mental health center staff and the public health nurses share a suite of offices, and nurses from the different agencies, public health, elementary schools, and Head Start, are in frequent communication.

EDUCATION FOR PARENTS

Education about child development and child management is available through the public health nurses, through staff at the mental health center, and through group classes at a private nonprofit organization called the Laramie Institute for Family Education (LIFE). The Team coordinator was instrumental in the creation of LIFE, reflecting his belief that many parents, whether or not in need of treatment, appeared unknowledgeable about management of children. Parents participate in a weekly discussion and study group, learning about child development and child management.

HEALTH SERVICES

The monitoring of children and their health status is available through public health, through the elementary schools, and through the Head Start nurse.

CHILD WELFARE SERVICES

D-PASS staff provides investigation of reported abuse and neglect, short-term counseling, 2 hours per day of day care, and foster care placements. Most cases are active for approximately 3 months.

CHILD DEVELOPMENT SERVICES

A few children (eight at present) who, as a result of serious neglect or abuse, show developmental lag, are accepted for services at the child development center. This is a center which provides initial screening/evaluation and an intensive stimulation program with a strong emphasis on the development of speech to retarded and handicapped children. Participation in the center's program by children referred by the Team represents an important treatment source for abused/neglected children in the community.

PARENT AIDE PROGRAM

The Team coordinator has trained four parent aides whose services are available to the Team. The parent aides, who receive supervision from the Treatment Team coordinator, act as a special friend to the client. The aide program is designed to help clients break their sense of isolation from others.

TREATMENT SERVICES

Treatment services to both adults and children are provided by the staff of the community mental health center. They include the Team coordinator, a psychologist with an Ed.D. degree at the mental health center, another psychologist with a Ph.D., the director of the mental health center, and four other part-time staff members who do not, however, have any major relationship to the Team or the families it serves.

The mental health center staff relies on a combination of therapy and education in child development and child management in dealing with abusive and neglectful families. Therapy is described as reality-oriented; very specific and distinct suggestions are made and subsequently discussed in order to see how they are implemented and whether or not they have helped. Families are seen on an average of once a week, but this may be more or less depending on the problem and on the relationship with the family. Therapy is often in the family's home, and the duration of sessions varies considerably. The mental health staff is aggressive in its outreach and makes no demands on the families in terms of an expectation that they be motivated for psychotherapy.

The overall treatment philosophy centers around a very positive approach to families both in terms of the therapist's communications about what can be accomplished and in terms of evaluation of strengths and assets on which to build. Therapy starts with the attempt to establish a sense of trust through communication of acceptance and through the fact that the therapist can be called on in a time of crisis, at any time.

The emphasis on education and on establishing a relationship of trust and support stems

directly from the treatment staff's underlying views of the causes of child abuse and neglect. They report that they have only rarely seen an abusive parent who was not herself/himself abused or uncared for and that therefore this is the only way the parents know to handle their own children. In other words, the view is that individuals who have had no loving, caring relationships themselves cannot be expected to enter into such relationships with their children. Thus, they must be taught a new way of relating to others through education and through the modeling of a caring relationship.

A significant, but unknown, proportion of families leave the county without any forwarding address or notification as to their whereabouts, and as a result many are lost in the process of followup.

The Team has carried a few cases for nearly 2 years and individual treatment staff describe cases in treatment over a 4- or 5-year-period. Some families are described as requiring lifelong therapeutic maintenance and followup.

The following cases are intended to provide information on the extent of service coordination and treatment techniques used by the Team.

Jane and Paul

Jane and Paul are both students with a 2-year old child who has cerebral palsy. Originally, the child was brought to the attention of the Team by the public health nurse because of his severe diaper rash and inadequate nutrition. The father believes in allowing nature to take its course and therefore does not believe in daily baths or in a planned diet.

Initial interviews with the parents by the mental health center social worker revealed that they were undergoing tremendous tensions in their relationship. Marital counseling was tried, but this was abandoned in favor of individual therapy when it became apparent that the marriage could not work.

The team referred the child to the child development center; his health status continues to be followed by the public health nurse. Currently, the therapist is exploring the possibility of a temporary placement for the child to give the parents some time to mobilize their individual resources. D-PASS is involved in planning for a foster home in which this child can be accepted and helped.

Therapy has involved education and guidance in terms of management of the child, ventilation of hostility and guilt concerning the child's impairments, and confrontation which is aimed at helping the parents acknowledge his very real limitations.

Denise

Denise was referred to the mental health center by her previous therapist in another State. She has a 3-year-old daughter with whom she sometimes loses control and becomes abusive. She is married to a man who dominates her and makes all decisions yet treats her kindly and with considerable patience, encouragement, and insistence with regard to her seeking help. Because she has little self-confidence, she appreciates his strength and his decisiveness, but she also resents him. Her daughter is described as a very demanding, stubborn child who would provoke Denise until she lost control. Denise was also drinking excessively at the time of the referral.

Denise, herself, came from an upper-middle class family with high expectations and frequent criticisms. Denise was seen in individual therapy once or twice a week and both she and her husband joined LIFE. Participation in one of the LIFE groups helped her to gain some skills in how to handle her daughter and in what to do before she came to the point of losing control. Participation in the LIFE program also helped Denise to be more tolerant of the child's play and need to explore her environment. She was able to decrease her excessive expectations in terms of cleanliness and neatness.

A parent aide was assigned to serve as a special friend to Denise. Over a period of months, the two spent many hours together talking, shopping, and sharing recreational activities.

Therapy was marked with periods of progress intermingled with periodic resistance, with open attempts at getting her therapist and parent aide to give up and leave her alone, and with one attempt at suicide by overdosing with a nonprescription analgesic and alcohol. Due to the persistence and the outreach of her helpers, continued contact was maintained foiling her efforts to terminate treatment.

After a year of therapy, the family moved, although Denise returns for followup appointments with her therapist and visits with her close

friend and former parent aide. It is reported that her ability to deal with her daughter has improved greatly, that she is far more self-accepting, and that the marital relationship has also improved. In addition, she has admitted to having an alcohol problem and has become quite active in Alcoholics Anonymous in her new community. In general there has been an increase in self-esteem, self-confidence, positive self-image, and independence and a decrease in her concern with the opinions of others, in her perfectionism and in her social isolation.

Florence

This case illustrates the extreme rigidity of some parents and the problems which can arise when a child who can adapt to one setting simply does not have the resources to survive another.

Florence is a school teacher who raised her 3½-year-old boy (Dick) by herself. She married a wealthy businessman, who had raised two sons of his own, when Dick was 3½. Dick, who was accustomed to an intense, warm, loving relationship with his mother, began to exhibit some difficulties at the time of the marriage. His stepfather perceived him as a "psychotic degenerate" and was convinced that he should be raised in the same manner as his own sons. This treatment included frequent beatings and a rigid diet to punish the child for going into the refrigerator without permission. The child was hospitalized with a bump on his head and it was noted that during the hospitalization he gained weight. He was released and readmitted for a concussion at which time it was observed that the child had lost weight. At this point, it became known that the stepfather was beating the child and restricting his diet. Dick was placed in a foster home and the parents were referred for treatment. The father refused to accept treatment because he felt that there was nothing wrong with him and that he knew exactly how to deal with this child. Despite considerable attempts to support her, the mother was unable to oppose or contradict him. Eventually, the boy's real father was awarded custody.

THE SERVICE DELIVERY SYSTEM

The functions and services of the agencies represented on the Team have already been described. Basically, the Team is perceived as a necessity for the following reasons.

- No single agency has the resources and expertise to deal with the problems of child abuse and neglect.
- The mandated agency has neither the trained staff nor the resources for coping with treatment or regular followup of child abuse and neglect cases.
- The Team serves a coordinating, information sharing, and planning function.
- The Team insures families against the possibility of falling in between the cracks. One Team member has primary responsibility for each case and during the weekly case review can expect to have to make a report to the Team on all contacts. This prevents cases from getting lost.
- In a rural area in which services are not extensively developed, the pooling of resources through the Team approach expands the total service capability. In a sense, the Team illustrates the old maxim that "the whole is greater than the sum of its parts." Most of the Team member agencies feel that Team membership has heightened awareness within their agency of child abuse and neglect as a problem and has led to a reevaluation of the importance of the problem. Public health, Head Start, and family planning nurses, along with mental health practitioners, characterize their agencies as being more sensitive and more responsive to the problem as a result of the Team's efforts.

SUMMARY OF KEY FEATURES

The Laramie Treatment Team is serving an important function as a coordinating and treatment resource.

The Council's functions are in terms of community education and are quite different from the functions of the Treatment Team. Presentations at various church and civic groups,

at PTA meetings, and at community health fairs are definitely within the scope of the Council. However, training and the availability of resource and education materials are necessary if the Council is to meet these objectives. Some funding may be necessary for the implementation of an effective community program.

The Laramie Program illustrates many of the benefits to be derived in a rural area from a team approach. It also illustrates some of the difficulties of achieving interagency cooperation, of resolving turf problems with the public social service agency, and of involving community professionals.

PART II
CHILD ABUSE AND NEGLECT: THEMES AND ISSUES

INTRODUCTION TO PART II

Part II provides a synthesis of the information obtained through the onsite visits to programs and a review of the literature. As part of this review nearly 300 books, journal articles, and reports (the majority published in the United States) were reviewed and abstracted in terms of their contribution to each of the following areas:

- criteria and definitions
- case reporting and incidence
- characteristics of abusers/neglecters
- characteristics of abused/neglected children
- identification, case management, and treatment
- social service, health, child care, educational, and law enforcement systems.

Each of these areas represents a chapter.

The literature on child abuse and neglect can be divided into two components: description and analysis based on observations of professionals and findings based on research studies or surveys.

Most of the literature reviewed is of a clinical, descriptive nature which is based on observations and generally consists of brief case history vignettes, generalizations based on experience, and theoretical discussions.

Seventy-five of the works reviewed represent research studies and surveys. Of these 75 studies, 31 are based on samples drawn from hospital admissions. Generally, these studies combine interviews with the caretaker and a physical examination of the child in conjunction with data from medical and social service records. Some of these hospital-based studies are retrospective. That is, the research is based on the records of children diagnosed as abused several years earlier and the cases are followed up to see what happened to the family in the intervening years.

Another basis for studies is referrals to private and public social service agencies, protective units, probation departments, and family courts. Case records are reviewed and, often, families are recontacted. Seventeen studies are of this type. Fifteen studies are based on cases referred to professionals for treatment, treatment programs, or teaching-research programs. Two studies deal with caretakers imprisoned for abuse. Two represent national surveys of press reports. Only one study has dealt with reported incidents on a national basis.

Only seven studies have dealt with agency and professional awareness, attitudes, and action. In these seven studies, the study procedure has generally involved the use of mailed questionnaires to professionals or hospitals.

Sample size in the 75 studies reviewed ranges from 10 to 6,617. Forty-three of the studies reviewed are based on sample sizes of less than 100 cases; 29 contain samples of under 50 cases. While some studies may begin with a substantial number of cases, inability to locate subjects for followup, refusal of subjects to participate, incomplete information and misdiagnosis, particularly in retrospective studies, reduce the sample of families studied.

In addition to the fact that many studies are based on a limited number of cases, most of the studies use skewed samples. Hospital-based study samples may have a preponderance of abuse in one ethnic or socioeconomic group because those are the people who use that particular hospital; they also have a preponderance of young children as these are the most vulnerable and most easily injured.

Comparison groups were used in only 10 of the 75 research studies, so that in the majority of studies which cite characteristics of abusers or of abused, there are no normative data on the incidence of these characteristics in the population at large. Without such normative data and without such comparisons, it is impossible to judge whether the characteristic in question is more or less endemic to abusive families than to any other group of families. A review of the research in this field leads to the conclusion that the majority of studies are so poorly designed that no generalizations should be made from the "findings."

Chapter notes, located at the ends of chapters V through IX, are keyed to reference numbers in the text. The complete reference for each of these citations can be found in the bibliography.

Chapter V — Criteria and Definitions of Child Abuse and Neglect

The existence of an adequate definition of abuse and/or neglect is central to the entire system of service delivery to abusive and neglectful families. Legal definitions delineate the range of cases and issues to which programs can be addressed. In virtually all communities there are children being subjected to severe physical punishment or being provided with a level of nurturant care which is lower than the average acceptable environment in that community. However, child abuse and neglect laws do not specify what is or is not acceptable in operational terms; hence there is no objective point of demarcation between punishment and abuse or between minimal acceptable care and neglect.

DeFrancis and Lucht (1974) report that most State laws use nonspecific language to define abuse. They cite as evidence such typical phrases as "serious injury or injuries inflicted upon him other than by accidental means" or "serious physical injury or injuries resulting from abuse or neglect and caused by other than accidental means" (p. 176). Some States define injury to include malnutrition, sexual abuse, and excessive corporal punishment. Although 38 States, plus Guam and the District of Columbia, make mention of both abuse and neglect in their "statement of purpose" clause or under reportable conditions, among these only 18 States have included legal definitions of abuse and neglect.

Legal definitions of abuse and neglect fall far short of providing the operating definitions necessary for intervention decisions, particularly because, as a function of cultural values and personal history, one man's abuse is another man's discipline. On a broader level, community standards differ in terms of the sociocultural definitions of acceptable discipline and of the relative weight given to children's rights in contrast to parental rights. In some communities the use of any object which leaves marks on a child's body is considered abuse; in other communities this depends on the age of the child, so that the strapping of a 12-year-old may be defined as nonabusive whereas the strapping of an infant is ipso facto evidence of abuse. Similarly, some programs take into account the location of the injury and are more likely to apply the label "abuse" in cases of physical marks to the face and genitalia than to marks on other areas of the body.

Standards used for the determination of abuse and neglect tend to vary not only across communities, but also across agencies within communities, thus creating problems in terms of differential eligibility requirements. For example, public health nurses and hospitals tend to have broader definitions of abuse and neglect than do public social service or child welfare agencies and the child welfare agencies tend to have broader definitions than do the juvenile courts. Thus, in some communities public health nurses and hospitals are frustrated by the public social service agency which is unresponsive to cases of failure-to-thrive and to "inadequate" home conditions. Similarly, in some communities the public social service agencies feel constrained by the legal definitions used by the juvenile court and find themselves helpless in cases where there are not actual physical marks on the child.

The definitional problem is more acute with respect to neglect than to abuse. For example, there exist no standard definitions as to what constitutes a minimal acceptable environment for children; agencies within single communities are in frequent controversy over whether or not a specific home environment is so deleterious as to endanger the welfare of children. In all communities we visited, case specific examples were provided to illustrate the problems of definition, e.g., is an alcoholic, a severely retarded, or a schizophrenic mother able to provide an acceptable home environment? If the parents cannot or will not provide food which meets the minimal daily nutritional

requirements, if the housing is substandard and so dirty that it can be declared a health hazard, if a child does not have clothing suitable to the weather—are these conditions definable as neglect? If parents feel that the natural oils of the body should be preserved and therefore bathe their child only once a week, with the consequence that severe diaper rash develops—is that to be defined as neglect, or simply "different" parenting? If parents choose not to use their food stamps for vegetables, fruit, milk, etc., and instead feed their children nothing but "junk" food, or if they refuse to immunize their children—is that considered neglect, or the exercise of parental rights? If a mother insists on sending her 10-year-old daughter to school in antiquated lace and organdy instead of in a pair of blue jeans, and the daughter is consequently laughed at and isolated by the other children—is that emotional abuse, or parental rights? If parents tie their 8-year-old child to a tree as a punishment for running away—is that abuse, or parental rights to discipline as they see fit?

Such questions comprise the basis upon which programs must make daily decisions regarding intervention and treatment. That is, cases are extremely common in which there is no actual medical evidence of abuse but in which the child has sustained an injury or bruises, in which the "dynamics" of abuse are present, and in which various conditions of neglect seem detrimental if not life threatening. Programs outside of the public social services agencies are more likely than public service agencies to persist in their efforts to induce such families to accept services. This happens because the former generally have smaller client-staff ratios and because they are not defined as an involuntary service, as are the latter which therefore tend to be more bound by legal definitions. If the services of a public social services agency are rejected, the decision to intervene is largely made on the basis of "what will hold up in court."

Definitional problems are compounded for those programs which try to work with "high risk" cases, generally defined as cases in which the dynamics of abuse are present in terms of the parents' backgrounds, their perception of the child, and the crisis-ridden, unstable nature of the home situation, but in which the child has not yet been abused, at least not to anyone's knowledge. In most such cases, if the parent rejects services there is little which can be done because there has been no overt damage to the child. For instance, programs have been confronted by cases in which a psychotic mother has threatened to cut off her child's arms and legs, cases in which a newborn infant has been sent home with a mother who has discussed the child's "evil intentions" with the nurse in obstetrics; yet the programs can do nothing in terms of compelling the parent to accept protective services. While hospital and social service staffs tend to be sensitized to potential signs of danger, if the parent persistently refuses service nothing can be done unless and until the child is injured. In this way, legal definitions which are limited to actual injury make preventive work difficult, if not impossible.

If the burden of proof of abuse "beyond a reasonable doubt" rests with the program, many cases go unserviced because accidental v. nonaccidental status is often difficult, if not impossible, to prove. For instance, if a toddler enters the hospital with third-degree burns all over his body and the mother says this happened because he turned the hot water on himself when she was called away to the phone, there is no way of proving whether she or the child turned on the water. Legally, if she turned it on because she wanted to punish the child for urinating in the bathtub, the incident is a nonaccidental injury. If he turned it on while she went to answer the phone, the injury is accidental.

While the law generally requires proof of guilt, most programs agree that the question of fault, of blame, of pinpointing "who did it" is not only unimportant, but is also potentially destructive to the development of a trusting, therapeutic relationship. Treatment staff agree that it is far better to approach the parent with the statement that "somehow it was not possible for you to protect this child from serious injury; we would like to help you work out ways to ensure that he is better protected." If, however, parents refuse services and if the burden of proof of injury is on the program staff, nothing further can be done. Every public social service agency and every community agency which makes referrals to the public social service agency can cite examples in which the parent refused services and the injury was not such as to permit a legal finding of abuse and thus no intervention was made—only to have the child reinjured at a later date.

Definitions of abuse in the general literature tend to be more specific than are legal definitions. Some are limited to physical abuse while others include emotional and sexual abuse. Showing the range of types of maltreatment, Silver (1968) has constructed a continuum of types of abuse and neglect with children who exhibit failure-to-thrive and malnourishment at one end and severe physical trauma at the other end. DeFrancis (1972) lists eight types of neglect and abuse: physical neglect, moral neglect, emotional neglect, medical neglect, educational neglect, physical abuse, sexual abuse, and community neglect.

There are a few well-known definitions which have achieved almost universal use by professionals in operating programs. One of the first definitions was the "battered child syndrome" offered by Kempe et al. in 1962. This phrase refers to unsuspected abuse manifested by repeated trauma, defined as "... a clinical condition in young children who have received serious physical abuse, generally from a parent or foster parent" (p. 17). More specifically, the term is used to describe the clinical picture of multiple fractures in the long bones, fractures of the skull, soft tissue injuries and bruises, and subdural hematoma. Programs visited by CRA do use this as one definition of abuse; availability of medical evidence of prior fractures in various states of healing makes this the easiest kind of abuse to prove in court.

Fontana's (1974) "maltreatment syndrome" has a different focus. This definition includes children without obvious signs of battering but with multiple minor physical evidence of emotional and nutritional deprivation, neglect, and abuse. Having a much wider scope, the maltreatment syndrome refers to a lack of food, clothing, shelter, parental love, as well as to physical abuse and mistreatment. It is Fontana's (1971) assertion that the presence of these conditions eventually leads to physical trauma in children. A general definition used by Newberger (1973) at Children's Hospital Medical Center in Boston is closely related to Fontana's. Abuse, with or without inflicted injury, is defined as a result of situations in a child's home which jeopardize his survival. Most definitions of abuse reflect the particular orientation of their author with little communality of definitional elements among authors. For example, Gil's (1970) definition, used in his large-scale study of child abuse incidence, differs markedly from others in that it specified that the abuse or neglect may be not only nonaccidental but may have a specific goal as well. Thus, he states that the "... physical abuse of children is the intentional, nonaccidental use of physical force, or intentional, nonaccidental acts of omission, on the part of a parent or other caretaker, interacting with a child in his care, aimed at hurting, injuring, or destroying that child" (p. 6). Recently, Gil (1975) has proposed a wider, more socially oriented definition, according to which abuse consists of "... inflicted gaps or deficits between circumstances of living which would facilitate the optimal development of children to which they should be entitled, and their actual circumstances, irrespective of the sources or agents of the deficits" (p. 347). Thus, Gil includes in this definition abuse or neglect by caretakers, by institutions which inhibit maximum child development, and by a society whose policies sanction or fail to overcome these deficits. The 1970 definition which specified intent and the 1975 social definition which includes societal agents as well as individuals as perpetrators of abuse set Gil apart from virtually all other authors.

Several authors including Galdston (1971*a*), Giovannoni (1971) and Komisaruk (1966) have made a differentiation between abuse and punishment. Galdston comments that abuse is not provoked by a child's behavior; it differs from punishment in that the child often is too young to be capable of deliberate actions or use of language as communication. This definition precludes any behavior on the part of the child which might precipitate an abusive incident. Giovannoni also differentiates between abuse and punishment by stating that abuse is an exploitation of the parents' or caretakers' rights to control and discipline their children. Komisaruk ties abuse to a deficiency of the central governing body in the abuser's personality. He provides the following definition: abuse is "... a condition of injury to a child resulting from the lack or suspension in a nominally responsible adult of the parental protective function accompanied by a release of unrestrained instinctual drive energy toward the child. This may be differentiated from discipline or punishment in that the latter are at least rationalized as being beneficial to the child" (p. 69). Yet in practice it is often difficult to distinguish between punishment and abuse because some parents do abuse their children

in the name of punishment and because some parents feel strongly that even infants should be punished in order to prevent spoiling. Program experience shows that abuse *is* often provoked by a child's behavior; soiling, crying, and messing are all child behaviors which can trigger either rage or a desire to punish in the parent. Moreover, many parents use physical punishment because they are unaware of alternative means of discipline or of producing desired behavior.

Elmer (1966) highlights problem areas with which definitions of abuse do not generally deal: (1) whether chronicity of maltreatment is necessary for abuse to be designated; (2) the degree to which ethnic or class identification determines how the caretakers are judged. The question of chronicity is important because many programs feel that a first incident of abuse will lead almost inevitably to a pattern of continued abuse; once the taboo against harming a small child is broken, the taboo itself is no longer operational and no longer works to protect the child. For this reason, the programs we visited did not require evidence of chronicity of abuse: a single, serious nonaccidental injury was considered evidence of abuse and of a parent in particular need of help to avoid almost certain repetition of abuse. However, while the question of chronicity does not seem to play an important role in the decision to work with the parents, it does play a role in some programs regarding decision to remove or not remove a child from his home. Once the taboo against injury is broken, some programs feel much more uncertain about sending a child back to his home. Class or ethnic identification is important in terms of decisions as to whether definitions of abuse or neglect should be absolute or should maintain cultural relativity, as will be discussed in chapter VI dealing with the reporting of abuse.

Also important in defining abuse is what Gelles (1975) terms the "social construction of child abuse." That is, " . . . the process by which: (a) a definition of abuse is constructed; (b) certain judges or 'gatekeepers' are selected for applying the definition; (c) the definition is applied by designating labels 'abuse' and 'abuser' to particular individuals and families" (p. 365). All three factors are important in determining what is to be considered abuse. They affect who is labeled an abuser as well as what the causes of abuse are considered to be.

Building primarily on the definition developed by Kempe et al. and by Fontana, quoted earlier, broader definitions have been developed by others.[1] The general definition of abuse from those sources is one of nonaccidental injuries as a result of acts of commission (physical assault) or omission (negligence or failure to protect) by caretakers, where medical attention or legal intervention is necessary.

While the State laws tend to define neglect in terms of physical needs as, for example, in Downs (1963), emotional neglect is discussed in the literature and by the staff at most programs, who do not feel, however, that they have the legal authority to work with parents who emotionally neglect their children. Mulford (1958) defines that phenomenon as " . . . the deprivation suffered by children when their parents do not provide opportunities for the normal experiences producing feelings of being loved, wanted, secure and worthy, which result in the ability to form healthy object relationships" (p. 4). Thus, neglect is a term which encompasses not only concrete elements such as food and shelter but also emotions and attitudes toward the child.

Definitions of neglect also fall prey to the overspecificity of various authors. There is somewhat more uniformity, however, in that most definitions of neglect, such as those provided by Brown and Daniels (1968) and Giovannoni (1971), focus specifically on acts of omission or failure by the caretaker to provide what are considered by society as vital elements of child care and nurturance: adequate supervision, nurturance, and protection. A general statement of neglect is provided by Galdston (1971*a*) who says that the neglected child has not received sufficient attention to promote growth and thus is retarded in terms of physical and psychological maturation.

This general definition is sharpened by Raffalli (1970) who makes note of either willful neglect or neglect borne of indifference and by Glazier's (1971) differentiation between parents who cannot afford to provide adequately for their children and those who can, and the accompanying suggestion that the "neglect" designation be applied only to the latter. Costin (1972) defines neglect partially in terms of parental desertion or emotional withdrawal as a result of alcoholism or depression. Lewis (1969) goes a step further by defining neglect as inadequate child care which is both persistent and which would probably not improve without outside intervention. Steele and Pollack

(1974) define neglect as a breakdown and failure in mothering; failure to feed or keep the child clean are two examples used in their discussion. Lewis (1969) dichotomizes neglect according to visibility. High visibility neglect includes physical deprivation, inadequate clothing, and poor personal hygiene. Inconsistent affectional relationships, inappropriate discipline, and irregularity of meals are examples of low visibility neglect.

Specific guidelines of what constitutes neglect are given by Polansky et al. (1972*a*). A child is neglected, that is, his growth and welfare are jeopardized when he is (1) malnourished, not properly clothed, unkempt, and without shelter, (2) without supervision, (3) lacking essential medical attention, (4) emotionally neglected, (5) fails to attend school regularly, (6) exploited and overworked, (7) emotionally disturbed due to a family dysfunction, and (8) exposed to immoral influences. These characteristics are similar to those summarized by Meier (1964) as being generally cited in neglect laws.

Failure-to-thrive is viewed by some as a physical manifestation of emotional neglect. It is a syndrome occurring among young children characterized by growth failure, severe malnutrition, and developmental retardation.[2] No organic cause is found to contribute to the syndrome. It is thought that neglectful social and psychological conditions foster failure-to-thrive and that a more nurturing environment will lead to improvement.[3]

On the basis of this review, it seems that the definition provided by Polansky, Hally, and Polansky (1974) is the most comprehensive. Neglect is " . . . a condition in which a caretaker responsible for the child either deliberately or by extraordinary inattentiveness permits the child to experience avoidable present suffering and/or fails to provide one or more of the ingredients generally deemed essential for developing a person's physical, intellectual, and emotional capabilities" (p. 10).

There is a gap between these broad definitions in the literature and the much narrower definitions used by child abuse and neglect programs. For instance, children who fail to attend school regularly are only rarely referred to protective services and even more rarely are their families serviced. Similarly, as already discussed, emotional neglect, improper clothing, inadequate shelter, and emotional disturbances in the child rarely lead to program intervention because of lack of definitional specificity.

Despite the fact that physically abused children are sometimes neglected and that neglect sometimes shades into abuse, most of the larger programs make an operational distinction between abuse and neglect. As described in part I, three of the programs visited (Children's Trauma Center, Oakland, California; SCAN, Little Rock, Arkansas; and Lehigh-Northampton Counties Coordinated Child Abuse Program, Allentown, Pennsylvania) serve abusive families and their children exclusively. SCAN, Children's Hospital, Pittsburgh, Pennsylvania serves primarily abused children because of its auspice. Bowen Center, Chicago, specializes in abuse and in neglect cases which are so severe that they shade into abuse. The child abuse and neglect teams in Laramie, Wyoming and in Billings, Montana have served both abuse and neglect cases. The Hennepin County Welfare Department, Minneapolis, Minnesota as a public agency serves both, but has a unit which specializes in abuse cases. Most programs, because of the urgency of abuse and the chronicity of neglect, do try to have a separate mechanism for handling abuse cases. Neglect cases far outnumber abuse cases; because of their more chronic nature, neglect cases are generally found to be more persistent and less amenable to treatment than are the more acute abuse cases.

NOTES

1. Boston Children's Hospital Medical Center 1974; Brown and Daniels 1968; Caffey et al. 1972; Elmer 1967*c*; Giovannoni 1971; Joint Commission on Mental Health of Children 1973; Raffalli 1970.
2. Joint Commission on Mental Health of Children 1973.
3. Barbero and Shaheen 1967; Bullard et al. 1967.

Chapter VI — Case Reporting and Incidence

In addition to their definitional aspects, the reporting laws of all States contain information about some or all of the following: the upper age limit of reportable children; a statement of who is required to report, how reports are to be made, and to whom; a statement of the role of the receiving agency after the report is made; and statements of immunity, waivers, penalty clauses, and the establishment of a central registry.[1] In addition to the above, 36 States have "statement of purpose" clauses which relate to the necessity of providing protection to the child, the prevention of further abuse, the provision of services, and the nonpunitive intent of the law.[2] These statements verbalize the intent and ultimate goals of the law.

IDENTIFICATION

In order for any reporting to occur, identification has to take place. It should be noted that in this chapter we deal with identification only as it relates to reporting. A more complete discussion of the processes and the mechanisms of case identification and validation appears in chapter IX on identification, case management, and treatment.

Identification of cases is difficult because of the definitional problems already discussed and because identification puts the reporter in an uncomfortable position vis-a-vis the abuser. In all of the programs visited, staff members urge professionals who identify a case of abuse to let the parents know in a supportive and nonaccusatory manner that someone has injured the child and that a report is being made to the appropriate agency or program. However, as will be discussed later, most professionals, even if willing to report, are unwilling to let the parents know of their intent to do so. It is our observation that willingness to confront parents and to let them know about the report comes only with specific training and with the presence of a clearly defined, visible, and relevant support system available to the reporter. When professionals receive specific training in how to communicate their concerns and intentions to parents and where there is a backup committee or task force which routinely provides consultation and support to the professional, letting parents know about the impending report is far more likely.

Hospitals, public health departments, school systems, day care centers, preschool programs, and mental health centers all need committees which can teach techniques of identification and ways of talking with parents in addition to providing consultation and support. In some communities, a multiagency interdisciplinary committee which meets regularly serves these functions; individuals within the various systems represented know that they can obtain consultation and support from the team member within their agency.

A number of authors discuss guidelines for physicians and other health professionals concerning identification and treatment of child abuse. For example, Helfer and Wheeler (1972) note four responsibilities of the medical practitioner: (1) early identification, (2) hospital admission of child, (3) confronting parents with the problem, (4) making arrangements for early referral. Helfer (1970*b*) provides additional guidelines for use in the emergency room. Helfer, as well as Cameron (1972) and Jackson (1972), emphasizes that a diagnosis of abuse must be considered a possibility for all small children exhibiting traumatic injury. Helfer also adds that the physician should not take the explanation for the injury given by the parent at face value. Any inconsistency could indicate a case of child abuse.

If abuse is seriously suspected, the child should be admitted to the hospital allowing for time and expertise to adequately evaluate the child. Riley (1970) recommends a coagulation survey and roentgenograms of long bones, ribs, and skull. Hughes (1967) has identified four symptoms and characteristics indicative of

abuse: (1) multiple and frequently repeated severe injuries; (2) injuries to the long bones, the ribs, and the skull, with subdural hematoma; (3) old and new injuries visible on x-ray; and (4) rapid recovery in the hospital in cases of failure-to-thrive. In addition to facilitating medical evaluation of the child, hospitalization allows time for medical and nursing staff to observe the parent-child relationship, provides protection to the child, gives the parents a cooling off period, and allows the staff to connect the parent with a variety of services.

Another responsibility of the physician is to form a clinical impression of the type and extent of the injury as well as an impression of the quality of child care. In order to evaluate the case and discover the manner in which the injury occurred, he needs information as to the parents' knowledge of child development, cultural mores, family dynamics, and psychopathology. Gray (1973) and Gregg (1968) list particular questions of which the physician should be aware where abuse is suspected. These include: does the explanation of accident adequately explain the injuries; if it is said that the child contributed to the accident, can this be developmentally possible; are there discrepancies in the parents' explanation; if more than one injury is uncovered, is the caretaker able to adequately explain all of them? In order to form a complete impression, Gregg recommends examining for surface signs of physical neglect and observing mother-child interactions.

Court and Kerr (1971), as well as hospital staff in several of the hospitals visited, describe one warning sign of abuse: when a mother repeatedly brings her infant to a physician or clinic with a complaint that something is wrong although no physical evidence is found. In such cases, most professionals recommend hospitalization of the child and discussion with the mother as to whether she has concerns that she will harm the child and would like help in this regard.

While among physicians it has typically been the pediatricians who have been in the forefront of work on child abuse, other physicians are becoming increasingly aware of and alerted to the possibility of abuse by their patients. Ryan (1974) suggests that obstetricians should observe their patients for the likelihood of abuse and neglect; an awareness of the expectant mother's attitude toward birth can aid in abuse prevention. Caffey et al. (1972) stress that particular attention should be given to women who have considered abortion, to young mothers, and to those women with a history of poor mothering and abuse. The Joint Commission on Mental Health of Children (1973) has recommended that general practitioners and nursing personnel be alerted to attitudes and characteristics of the mother.

In general, among all the communities we visited, in those hospitals which have a child abuse team, there is awareness of the various signs and possibilities for abuse. Moreover, in some hospital-based programs there have been noteworthy efforts to work with the maternity hospital or service. For example, nursing staff in maternity hospitals and services have been alerted to the mother who appears to be under great stress, to the mother who appears isolated and has no source of support, to the mother who displays strange ideation about what the child will be like and his potential for evil, to the mother who appears angry and resentful toward an unwanted baby, and to the mother who has to undergo prolonged separation from a premature baby. The importance of referring these potentially "high-risk" women to the hospital social services department is well recognized in some hospitals as is the need for coordination with the children's hospital or the pediatric service which will provide medical checkups for the infant.

Once a case has been identified or once there are reasonable grounds to suspect abuse or neglect, reporting is a next step.

REPORTING

While all States encourage reporting by everyone, they also *require* that certain persons report. For example, in most States physicians are mandated to report on the grounds that they are often the first persons to learn of an occurrence of abuse. Other professionals who may be mandated to report are nurses, teachers, day care staff, social workers, psychologists, and law enforcement personnel. Some States go one step further and require reporting from anyone with reasonable cause to suspect abuse. Avery (1973) has recommended that reporting be made mandatory for representatives of any group in ongoing contact with children. Since the passage of reporting laws, there has been a trend toward increasing the number of professions required to report with a growing

number of States developing mandatory rather than elective reporting laws.[3] Most States also have a penalty clause which is invoked when mandated reporters willfully fail to report an incident of abuse. Many feel that mandated reporting is a means of supporting physicians and other professionals who can point to their legal responsibilities when confronted with parental anger.

An immunity clause is included in the laws of all 50 States. This clause ensures that anyone reporting an incident of abuse will not be the target of civil or criminal suits as long as the report was made in good faith. Waivers of the confidential doctor-patient and husband-wife relationships are also included in the majority of State laws, the latter because the parents may be the only witnesses in an abuse proceeding. Still preserved, with few exceptions, is attorney-client confidentiality.

Facilitators and Barriers to Reporting

Mandated reporting clauses raise questions concerning the interrelationship among the duty of the reporter, the rights of the parents, and the welfare of the child. Some physicians feel that their role in reporting conflicts with their role as healer. If, as a healer, the physician deems it in the child's best interest not to report his suspicion, then there is a conflict between his legal obligation to report and his ethical training which stresses that a physician must cause no harm. When the reporter is a physician in office practice without the means to conduct a social investigation necessary to assess the child's situation, mandatory reporting might lead to incorrect accusations and to considerable harm.[4] Diagnostic guidelines are not well drawn; certainly this type of assessment is not emphasized in medical education. In addition, the physician in private practice has a conflict in that the law requires that he report the very parent with whom he has contracted for services and who is paying his fee. Virtually all authors on the topic recommend that physicians have available to them an abuse resource office to provide them with guidance in reporting and managing abuse cases. The availability of such a resource office promotes reporting in two ways: it reinforces the reporting behaviors—something "is done" as a function of the report in an immediate, discernible sense; the availability of formalized support legitimizes the act of reporting with respect to what is, for many, a taboo subject.

In 1962, Kempe et al. wrote that physicians were often emotionally unwilling to consider the possibility of abuse to the point of refusing to accept radiologic evidence which pointed to maltreatment. There is a reluctance to admit that it is possible for parents to abuse their children and that all parents do not love their children.[5] In addition, Fontana (1971) has commented on the unwillingness to report incidents " . . . due to lack of information and/or a desire to protect (the) patient from embarrassment based on little evidence or mere suspicion" (p. 5). Physicians receive little training in communication skills and communication in the highly charged area of abuse is particularly difficult. Helfer (1974) has pointed out that when doctors and patients have a long-standing relationship, especially if this relationship is a social as well as a doctor-patient one, as is the case in small towns, reporting can be especially difficult. Moreover, especially in small communities, physicians are concerned lest their reporting activities damage their reputations and lead to a loss in their practice.

Although all State laws have provisions granting immunity to the reporter, fear of malpractice suits or other court involvement is still prevalent.[6] Fear of legal action and concern of violation of the doctor-patient relationship (even though this provision is waived in most States) has also led to a refusal by physicians to open their records to law enforcement officials. Since there is no other area of practice in which a physician is required by law to make a report on any of his patients, physicians have no experience with reporting and express concern that child abuse laws may be setting a dangerous precedent in terms of reporting on patient activities.

Finally, many physicians do not know to whom and how they should make a report so that it is important to make these procedures simple and well defined.

In most of the communities visited, local hospitals have taken initial steps leading to the creation of a child abuse committee or task force which assists in the diagnosis and initial management of child abuse cases. Such groups within a hospital are absolutely necessary as a mechanism for (1) setting up procedures to ensure that all children entering the hospital

are screened for possible abuse; (2) providing training to interns, residents, and new physicians; (3) providing consultation to physicians who are uncertain and have little experience with abuse; and (4) sensitizing physicians, so as to encourage case reporting. Hospitals which have instituted such committees can point to a dramatic increase in the number of identified and reported cases dating from the implementation of the committee functions. For instance, at one hospital visited, identification of child abuse rose from 7 cases per year to 230 cases per year accompanying creation of a child abuse team; at another hospital the number of identified cases per year rose from 19 to 173 during the first year of the team's operation. Hospitals which do not have such procedures tend to report remarkably few cases; it is difficult to avoid the conclusion that they are underreporting either because they have not identified cases or because they do not understand the need for reporting.

In our experience, mental health center staffs, except those which include a specific child abuse team, tend not to report abuse cases because they feel that the act of reporting is inimical to the therapeutic relationship. Prevalent opinion among mental health professionals seems to be that as long as the parent is in treatment, the child will not be seriously injured. Yet nearly all child abuse program staffs cite cases in which children have been seriously abused while a parent was in treatment in a mental health center. In fact, based on the cases cited during the field visits, it can be concluded that the positive feelings toward the parents which are so necessary to the establishment of a positive therapeutic alliance may well cause the mental health professional to overlook the danger to the child. While a mother may be making progress in treatment, the child may still be in grave danger and should be known to protective services.

Another constraint to reporting stems from the view that parents have the right to discipline their children as they see fit. As already discussed, the line between legitimate punishment and physical abuse is often not distinct. While child protection laws are based on the idea of the state as "parens patriae" or the State as guardian of the physical, mental, and moral welfare of children, there is still the wish to preserve freedom of childrearing for the majority of parents.[7]

Cultural and socioeconomic factors also play a part in determining the types and amount of punishment to be allowed in raising a child. First, the reporter must determine what is beyond reasonable and safe punishment, while simultaneously taking community standards into account. Some authors feel that the diagnosis of abuse, rather than punishment, may only reflect a difference of values between family and physician. Upper-class and white children may be diagnosed as failure-to-thrive or accident cases while children of lower socioeconomic status or of a minority ethnic group with the same symptoms may be judged to be abused.[8] Second, the value system of the professional, itself a function of his/her background and social milieu, directly affects perceptions of what is and what is not abuse. For example, we were told about a discussion between two pediatricians in a modern, large city hospital as to whether manifold welts on an 8-year-old male's legs and back constituted abuse. One pediatrician, the product of a middle-class background, felt strongly that this was abuse; the second, who had grown up in an urban ghetto, recalled the many times in which *he* had been similarly punished, as had been his peers, and felt that such physical punishment was not abusive.

Some professionals feel that mandated reporting may further endanger the reported child. Lack of resources may mean that a child who is reported abused will only be returned to the abusive family and that their anger may isolate the child from additional medical assistance when needed. In somewhat related fashion, professionals also feel that the fact of reporting does not produce desired goals. Fear of prosecution may lead the parents to withhold information, to lie about the child's history, and to seek care from a different medical source after each incident, all hampering treatment of the child. Reporting of cases is not an end in itself; reporting laws should not be structured to drive families away from medical attention.[9]

Two studies deal with the reporting attitudes of health professionals. Bleiberg (1965) questionnaired 200 physicians working in 88 New York City Health Department child health stations. Only 12 physicians responded; 18 cases had been reported in a 1-year period. Silver et al. (1967) distributed questionnaires to 450 pediatricians, general practitioners, and hospital emergency room staff in the Washington, D.C.

metropolitan area; responses were received from a total of 198 persons (44 percent). One finding was that almost one out of four responding physicians replied that they would not report a suspected abuse incident although legally mandated to do so. The prevailing attitude was that the evidence would not stand up in court. Other responses include the difficulty (1) in accepting the occurrence of willful abuse, (2) of understanding the various degrees of neglect and abuse, and (3) of understanding their own responsibilities and those of other agencies involved in child abuse and neglect cases.

Several research studies provide data on reporting sources. Michael (1972) discusses a survey of 455 children abused in Iowa from 1967 to 1969. The most frequent reporting sources in these cases were public and private social agencies (28 percent), school and child care facilities (20 percent), and other sources such as relatives and neighbors (20 percent). Private physicians only reported 9 percent of the cases and hospitals only 10 percent.

Bain (1963), Bryant et al. (1963), and Merrill (1962) all discuss a study of 180 children from 115 families referred to the Massachusetts Society for the Prevention of Cruelty to Children. Twenty-four percent of the referrals were made by relatives of the abuser, 23 percent by legal authorities, and 22 percent by neighbors. Only 9 percent were referred by physicians, although medical personnel had been involved in over 30 percent of the cases. Bain summarizes the failure to report as due to all of the factors mentioned earlier: misdiagnosis, absence of social conscience, inability to perceive parents as abusers, fear of legal proceedings, and lack of knowledge of the physician's responsibilities.

Lack of reporting by medical personnel is described by Simons and Downs (1966, 1968) in their documentation of medical reporting to New York City Bureau of Child Welfare. In the first year after legislation was effected, medical sources reported 293 families; this number increased to 315 families in the second year. The third year, however, saw a marked drop in reported incidents. Private practitioners reported less than 3 percent of the cases.

In 1964, Syracuse, New York instituted a school-based reporting program and established a central registry. School personnel were guaranteed immunity relative to reported cases of abuse which were made to the health service and the social welfare department. Murdock (1970) reports that over a 4-year period 20 cases were reported per year by nurses, teachers, and principals (in that order of frequency).

Among the programs we visited, large urban pediatric hospitals or general hospitals account for approximately 25 percent of the abuse referrals to protective services. In communities which do not maintain a hospital team and in which no one from the local hospital participates on the community-based interagency team, hospital reporting is minimal.

One point stands out from a review of literature relevant to reporting: After approximately 10 years of child abuse laws and the discussion of reporting responsibilities, professionals in contact with abuse still fail to report, and reporting procedures are still not clear to most. Identification and reporting seem to be maximized where professionals within an institution or an agency have received training dealing with child abuse and neglect and have access to a visible and experienced team which can provide them with consultation, support, and legitimacy.

In the communities we visited, it was known that many professionals still neither identify nor report cases of abuse. Pediatricians in private practice, many hospitals, school systems, mental health centers, and child guidance clinics which do not have access to an agency or to a community team support system or which have an administrative policy against reporting tend to minimize child abuse and neglect and to ignore their professional responsibility in this area.

While professionals initiate most reports, in most communities many reports are also initiated by the lay public, i.e., friends, relatives, and neighbors. However, there has been little systematic study of public willingness to report and of public attitudes toward abuse and neglect.

Boehm (1964) distributed over 1,700 questionnaires to a sample of community leadership groups in urban and rural Minnesota. On the basis of the 81 percent return to this distribution, Boehm concluded that the community leaders strongly supported protective action in cases of gross physical harm to a child. On the other hand, emotional neglect or mental health hazards were not taken into account unless accompanied by violence of a physical nature. In addition, the community's definition of neglect and protection was shaped by the socioeconomic characteristics of the population deemed to be abusing and neglecting. That

is, abusers and neglecters were generally thought of as representing low socioeconomic status groups.

Part of Gil's study *Violence Against Children* (1970) included a nationwide survey, completed in 1965, of public knowledge, attitudes, and opinions about physical abuse in the United States. Using a probability sample of the noninstitutional population over 21 years of age (married persons under 21 years old were also included), Gil surveyed the opinions of 1,520 respondents. His findings include the following: There was a high awareness of the general problem, over 80 percent had recent knowledge of physical abuse. Respondents with greater than high school education were more knowledgeable than the others. Least knowledgeable were residents of nonmetropolitan areas with less than a high school education. Besides a more general knowledge of the subject, nearly 80 percent knew of one or more particular incidents of abuse, the majority from newspaper coverage. Three percent had personal knowledge of a family where abuse had actually occurred during the year prior to the survey.

Gil and Noble (1969) report relatively fewer respondents had specific knowledge of agencies relevant to the detection, report, and treatment of abuse. In nonmetropolitan areas such knowledge was highly related to respondent educational level. However, nearly half of the respondents indicated that they would, in fact, notify the local welfare department to report an incident; this response was given more often by respondents with higher levels of education.

Gil (1970) also reports that a majority (58 percent) of the respondents were of the opinion that " . . . anybody could at some time injure a child in his care" (p. 5). In fact, such injuries were viewed as almost normal occurrences in childrearing. However, when Gil made the question more personal, that is, when he asked whether the respondent could cause injury to his/her child, only 22 percent answered affirmatively. Thus, while professionals and community leaders may have an unclear idea of the nature of abuse and what it constitutes, the public is, at least, generally aware of the problem's existence.

In nearly all of the communities visited, the child abuse and neglect programs have made (in some cases extensive) efforts to provide public education. Programs often maintain a Speaker's Bureau which, in different communities, may be composed of community team professionals, representatives from lay organizations such as the Junior Women's League, members of Parents Anonymous or other formerly abusive parents, and agency staff. These individuals make presentations to civic groups, to PTA groups, and to other groups of concerned citizens. The demand for speakers usually outstrips their availability. A number of the programs have also participated in radio and television programs and have developed information pamphlets for distribution at community health fairs or to community groups.

Staff in some of the programs visited point out that the public information campaigns designed to alert the public to the need for reporting have two associated dangers. Public reporting campaigns have, in some instances, produced a rise in reporting which far outstrips the increase in services with the result that cases either go uninvestigated or that families receive no services subsequent to the investigation. Well-intentioned public information campaigns which focus on the brutality of abuse as a means to overcoming reluctance to report may serve to harden attitudes of condemnation of abusive parents. The danger is that in such a community the result will be a public hue and cry for more criminal prosecution and less allocation of funds for services to families. Thus, public information campaigns should stress the fact that abusive parents can be helped and that there are resources to which people can turn if they feel they are experiencing serious difficulties with their own parenting, as well as the importance of reporting and of reporting procedures.

There is impressionistic evidence that efforts directed toward public education are rewarded by an increase in self-referrals and community referrals. However, the impact of community education programs on self-referrals, on lay willingness to make referrals, and on the general level of public knowledge and attitudes toward abusive and neglectful parents has not been studied systematically.

Receivers of Reports

A variety of agencies are mandated to receive reports; reflecting changes in the understanding and approach to abuse, the type of agency so mandated appears to have changed over the last

decade. DeFrancis (1973) states that in 1963 the first child abuse reporting laws required that reports be sent to law enforcement agencies. However, accompanying the development of a less punitive approach to abuse, the tendency has been to require reporting to the public social service agency. DeFrancis and Lucht (1974) note that "... 43 States require that reports of child abuse be directed to the department of social services at the state or local level" (pp. 177-178). In 30 States, at least one additional agency, typically the police or county attorney, is also mandated to receive reports. DeFrancis and Lucht (1974) report that seven States designate four or more agencies as receivers of reports, creating confusion for the reporter and producing differential treatment for the abuser, depending on the type of agency to which the incident was initially reported.

While most professionals sophisticated in the detection and treatment of abuse favor reporting solely to the public social service agency, such action requires that the public agency be adequately organized and staffed to provide protective services. In communities where this is not the case, dual reporting responsibility may serve as a gadfly to the public agency to improve its services. In other words, when the county attorney receives all reports and wants to know what is being done by the public agency, or when the police department receives reports and wants to know what is being done, and when these agencies have the authority to ask, pressures increase on the public agency for delivery of service. While law enforcement officials tend to be viewed by social service staff with considerable misgivings, given adequate training in abuse and neglect, law enforcement officials can be both sympathetic and effective.

Age of Children

State laws vary in terms of the age limit for mandated reporting. DeFrancis and Lucht (1974) report that 18 is the upper limit in the greatest number of States. However, age limits range from age 12 in some States to others which include the mentally retarded or any incompetent or disabled person, regardless of age. In most States, the age limit for inclusion in the reporting law is the age limit which defines the jurisdiction of the juvenile court.

Abuse Laws Under Criminal Codes

Abuse laws are either accusatory or non-accusatory. In the former, the reporter may have to identify the abuser as a caretaker of the child and, in most cases, show that the injury was intentional. DeFrancis and Lucht (1974) and Ryan (1974) recommend that the reporting laws not be accusatory, i.e., subject to criminal court jurisdiction, as this places an extra burden on the reporter. Other authors have discussed the inappropriateness of placing child abuse laws under the criminal code.[10] Criminal law requires firm evidence of guilt which, as already discussed, is difficult to obtain, particularly because the abused is typically too young to testify. Neglect, in particular, is a difficult problem because it is often impossible to obtain enough physical proof of neglect.

Avery (1973) estimates that only 5 to 10 percent of abuse cases lead to conviction. He sees criminal prosecution in abuse cases as misdirected because it tends to make the family more unstable and to isolate it even further from the community. Such action does not require that treatment procedures be instituted and may also lead to additional hostility toward the child. In any case, it does not make the child's future more secure.

Staffs of all treatment programs visited believed strongly that parents should not be prosecuted in criminal court because the "criminal" label is intrinsically antitherapeutic, destroying the possibility of rehabilitation. Some programs are instrumental in helping parents facing criminal charges to find a lawyer who can defend them successfully. On the other hand, most staff members viewed juvenile court as a potential therapeutic ally.

With few exceptions, it seems that the more highly developed the treatment program, the more willing are county attorneys to forego criminal charges. Where treatment services are not highly developed or are perceived by the county attorney as relatively ineffective, prosecution is far more likely. As one county attorney put it, "... social services have really not been able to handle the problem and until they can, we have to deal with it in a law enforcement manner."

Central Registries

Since child abuse laws were first instituted there has been a trend toward the creation of central registries which exist, according to DeFrancis and Lucht (1974), in 33 States. The function of these registries varies from State to State. In most States the registry serves as an information system for identifying repeated incidents of abuse with respect to the same child or within one family or as a research instrument for helping in the study of incidence of abuse and its characteristics. The registry may also be used as a tracking system to ensure adherence to a service plan and periodic case review. Differences among States occur in terms of who has access to the listings, whether the registry contains validated and unvalidated reports, and whether entries are expunged after a certain period of time or when the child is beyond the reportable age limit.[11]

INCIDENCE

Estimated incidence rates of abuse and neglect are widely divergent and often questionable as to their accuracy. A number of factors contribute to this situation.

First, as discussed in chapter V, there is no uniform definition from State to State as to what constitutes an act of child abuse. Some States refer to serious physical abuse, i.e., the battered child syndrome, while others include moderate and mild abuse. Clear requirements for inclusion in these categories are often not given and the use of different standards makes the States not comparable. Therefore, estimates based on reported incidents in one State and extrapolated to the Nation may be quite different from an estimate based on extrapolation from reported incidents in another State.

Second, because reporting is closely tied to the availability of a support system for professionals, to changes in reporting laws and the degree of public information, and to the availability of effective treatment programs, the recent growth of these systems and programs has resulted in a sharp increase in reporting. Therefore, incidence studies are especially vulnerable to the timeframe in which they were conducted. A striking example of this is offered by Cohen (1975) in his discussion of the State of Florida which in 1970 reported 17 cases of child abuse and in 1971, following the installation of a well-publicized hot line, reported 19,120 cases.

Third, as was discussed earlier in this chapter, estimates based on reported incidence reflect a bias toward those groups which are more susceptible to report. For example, lower socioeconomic groups, which typically use a hospital emergency room rather than a private physician, are likely to be overrepresented. Private physicians, although suspecting the presence of abuse, may nevertheless be unwilling to report it.

Fouth, incidence estimates are based on data from different sources. Data from State registries, from surveys of physicians and hospitals, from newspaper surveys, and data extrapolated from surveys of persons who know first hand of an incident, all lead to varying estimates.

Fifth, abuse incidents may never come to the attention of medical personnel or they may be misdiagnosed. Holter and Friedman's (1968*a*, 1969) studies of accident cases have shown that when records were reviewed several years after hospital admission, many of these cases were found to be incidents of abuse which had gone unreported.

An early estimate of the occurrence of child abuse is given by DeFrancis (1963). He found 662 cases of abuse reported in the newspapers of 48 States and the District of Columbia during 1962. In a survey (1962) of 71 hospitals Kempe et al. found that a total of 302 cases had been reported; 77 district attorneys who participated in the survey knew of 447 cases in that 1-year period. Trouern-Trend and Leonard (1972) state that in Connecticut, reported incidence increased from 102 cases in 1967/68 to 378 cases in 1970/71. Young (1964), in a study of 120 case records from two public and one private child welfare agencies (urban and suburban) in an eastern metropolitan area, found that 75 percent of the cases reviewed showed a history of abuse. In a second study of 180 records from agencies in seven localities (urban and rural) around the country, she found abuse in 44 percent of the cases. One of her conclusions was that abuse occurred most frequently, as well as more severely, in heavily populated areas. This is also illustrated in an analysis of reported incidents in New York City, Simons et al. (1966). They found that three boroughs (Bronx, Brooklyn, Manhattan) with the highest concentration of reported incidents had common characteristics as contrasted with the

remaining boroughs. These characteristics include increased crowding, a high proportion of births to Puerto Rican and noncaucasian mothers, more low-weight newborns, late or no prenatal care, and higher infant mortality rates.

In his 1967/68 survey of every incident of child abuse reported through legal channels in the United States, Gil (1970) found approximately 6,000 cases, reporting a net increase of 10.4 percent from 1967 to 1968. Helfer and Pollack (1967) report that, in 1966, 10,000 to 15,000 children in the United States were seriously injured by nonaccidental means; of these, 5 percent were killed and 25 to 30 percent were permanently injured. DeFrancis and Lucht (1974) also estimated the incidence of serious child abuse to be at a level of over 10,000 cases per year. Zalba (1971), extrapolating from State data, says that approximately 30,000 to 37,500 children need protection against serious abuse. However, he also states that a conservative estimate of children in the United States needing protective services because of abuse and/or neglect reaches about 200,000 to 250,000. Another widely quoted figure of estimated national abuse was reached by Kempe and Helfer (1972). Based on 22,000 reported cases in Denver and New York City, they estimate between 250 and 300 cases per million population per year. This would result in approximately 60,000 incidents per year in the United States. Kempe (1969) has also estimated that 15 percent of emergency room visits per year of children under 5 years of age are for child battering.

Gil and Noble (1969) propose a much higher incidence rate. In their 1965 survey of knowledge, attitudes, and opinions of the general public, they found that 3 percent of the sample had personal knowledge of a family in which abuse had occurred during the year prior to the survey. They then extrapolated to the total United States population assuming that each respondent knew a different family. The national estimate, then, is 2.53 million to 4.07 million abuse incidents. This is the highest figure estimated by anyone to date.

Light (1973) revised Gil's estimate based on the adjustments that (1) each respondent in Gil's sample knew more than one family with at least one child less than 18 years old and that (2) it is possible to divide the respondents' knowledge of families into those known well, moderately known, and only known slightly. Light then assumed that the respondent was more likely to know of an incident of abuse if it occurred in one of the families he knew well and that the more families the respondent knew who had children under 18 years of age, the more likely he was to be aware of abuse. Thus, Light estimated that between 0.004 and 0.01 of all families in the United States physically abuse a child each year. There are 31 million families with children under 18 years of age which leads to a lower estimate of 124,000 abusive families. If, however, more than one child per family is abused, the rate is even higher: from 200,000 to 500,000 cases per year.

Estimates of other types of maltreatment, such as neglect and sexual abuse, are also published although it should be remembered that they are subject to the same problems as are the rates for physical abuse. DeFrancis (1972) reported that in 1967 there were 3,000 cases of confirmed sexual abuse in New York City; Schultz (1973) gives a national average of over 5,000 cases per year of incest.

Jetee in Polansky et al. (1972*b*) identified neglect as the principal problem for 43 percent of children in foster care served by public agencies in 1961. According to Fontana (1971) in 1962, over 5,000 dependency and neglect cases were dealt with in New York City's children's court; according to Solomon (1973), by 1970 that figure had risen to 10,000 neglected children. Fontana (1971) also states that 800 cases of neonatal addiction occur in New York City each year. He estimates a 15 percent to 20 percent rise in incidence in recent years.

Polansky compares neglect statistics with those for abuse. In North Carolina, 2,258 neglect cases were reported in 1969-70 compared with 195 abuse cases, a ratio of approximately 10 to 2 (Polansky et al. 1972*a*), while in Florida the ratio was approximately 3 to 1 (Polansky, Hally, Polansky 1974). There is general agreement that neglect is far more common than abuse. While a great deal is written about the number of abuse incidents that go unreported, the number is probably much higher for neglect cases because, as noted earlier, neglect is more difficult to define and prove.

Since incidence studies are limited by the degree of public and professional awareness and willingness to report at any given time in history, by the sources from which data are collected, and by legal and operational definitional differences between communities, it is

highly doubtful that such studies can generate any valid estimates of the incidence of abuse. In our opinion the expense of such studies is in no way justified by the quality of the results achieved.

NOTES

1. DeFrancis and Lucht 1974.
2. Newberger and Hyde 1974.
3. DeFrancis and Lucht 1974; Newberger and Hyde 1974.
4. American Academy of Pediatrics 1966; Elmer et al. 1971.
5. Reinhart and Elmer 1968.
6. Costin 1972; Fontana 1971; LeBourdais 1972; Paulson and Blake 1969; Sanders 1972.
7. Meier 1964; Nyden 1966.
8. Boston Children's Hospital Medical Center 1974.
9. Besharov 1974; Corbett 1964; Elmer et al. 1971; Galdston 1971*b*; Schaffer 1965; Silver et al. 1967; Trouern-Trend and Leonard 1972.
10. Avery 1973; Burt 1971; Paulsen 1966*b* and 1974.
11. Newberger and Hyde 1974.

Chapter VII – Characteristics and Dynamics of Abusers/Neglecters

INTRODUCTION

This chapter presents a synthesis of the literature and of program experience in terms of the characteristics and dynamics of abuse and neglect. This information is organized into the following categories:

- Demographic characteristics, i.e., socioeconomic status: income, occupation, and education; age; family size and spacing; ethnicity; intact v. single parent status
- Life history characteristics, i.e., alcohol and drug use; history of court involvement; physical and mental disabilities
- Dynamic characteristics, i.e., child-related knowledge, attitudes, and behavior; childhood experiences and role modeling; relationship stress; self-concept; isolation
- Explanatory theories, i.e., psychological explanations; sociological/environmental explanations; sociopsychological explanations

While some studies are addressed to, or include, perpetrators other than the biological parent or other principal caretakers, most do not. Therefore, this chapter follows suit in addressing itself only to characteristics of abusers who are natural parents or principal caretakers.

DEMOGRAPHIC CHARACTERISTICS

Socioeconomic Status: Income, Occupation, and Education

Samples used in several studies include abusers at all socioeconomic (SES) levels. For example, Steele and Pollack (1974) report that the 60 families they studied and treated were from various social classes. Based on their review of medical records of 50 failure-to-thrive cases at Boston Children's Hospital, Glaser et al. (1968) report that all classes are represented. In the descriptive literature, child abusers are also said to represent all SES levels.[1] However, while abusers from higher socioeconomic levels are occasionally encountered, lower socioeconomic levels are overrepresented among reported cases. Most authors report that this overrepresentation of low-income groups is due to their greater use of emergency rooms and public social services; families belonging to higher SES levels more often use private physicians who, in turn, tend not to report abuse to the mandated authorities.

Gil (1970) found that lower-income SES groups were overrepresented in his national sample of approximately 6,000 reported child abuse cases; 60 percent of the families in Gil's survey were receiving public assistance. Zuckerman et al. (1972) report that 72 percent of 60 hospitalized abuse cases at Columbus Children's Hospital, Ohio had an annual family income of less than $5,000. Elmer (1967*c*), comparing the characteristics of 31 abusive families whose children were hospitalized at Pittsburgh Children's Hospital with those of the general Pittsburgh population, reports that 25 percent of the abusers received public assistance as contrasted with only 5-6 percent of the general Pittsburgh population. Not surprisingly, financial problems are frequently listed as a characteristic of abusive families.

Comparisons between income of program participants and of community residents in the program case studies presented in part I show that lower-income groups are overrepresented among abusive and neglectful parents. Virtually every program has worked with middle- and upper-middle-income families and it is absolutely clear that high income does not preclude child abuse. Nevertheless, whether it is because of the greater visibility of low-income families in community agencies or whether it is because of a greater true incidence among low-income families, these

families are overrepresented in the programs visited.

Occupations listed by families in studies reported in the literature are also of a low level. Skinner and Castle (1969), studying British National Society for the Prevention of Cruelty to Children (NSPCC) records for children who received medical care for abuse, report the following levels of skill in the 78 families: 54 percent unskilled, 9 percent partially skilled, 26 percent skilled, 11 percent unknown. Paulson et al. (1974) found, among their sample of 31 families referred to a group psychotherapy program, unskilled, skilled, manual, and clerical workers.

Unemployment rates are also high. In 21 percent of a sample of 60 abuse cases (Zuckerman et al. 1972), the father or male guardian was out of work. Over 50 percent of the sample families (303 abuse cases) studied by Boston Children's Hospital Medical Center (1974) were unskilled or had never worked. Holter and Friedman (1968*a*) found that 32 percent (N=10) of their high-risk families were unemployed compared with only 8 percent (N=5) of the low-risk families at the University of Rochester Medical Center. Determination of risk was made on the basis of types of injuries to a child. High-risk families included all cases of head injuries, fractures and dislocations, limb injuries, burns, abrasions, contusions, and bruises. Low-risk families consisted of cases of lacerations and ingestions. Young (1964) mentions unemployment as a characteristic of 120 abusive and neglecting families she studied but gives no proportion of its presence in the sample. Several other authors of descriptive works also mention unemployment as being high among abusive caretakers.[2]

Although employment data are generally not systematically collected in the programs visited, the majority of abusive parents have low-level occupations or are unemployed. Several programs reported that at times of massive layoffs within their communities, there is a rise in reported cases of abuse among workers in those industries. The father's tension over his loss of employment and his unaccustomed presence in the home are generally felt to contribute substantially to the potential for abuse.

It is also generally reported that parents in these families have had little education. Nurse (1964), in a study of 20 families known to New York Family Court, reports that the average level of education is 9 years. Komisaruk (1966) and the report by the Boston Children's Hospital Medical Center (1974) state that one-half or more of their samples (65 families at a Detroit child study clinic and 303 hospitalized abuse cases, respectively) had less than a high school education. Approximately three-quarters of the parents of 60 hospitalized children reviewed by Zuckerman et al. (1972) had not completed high school. Holter and Friedman (1968*a*) compared family background of 34 accident, 33 repeated accident, 10 suspected abuse, and 10 neglect cases. In terms of education, they found that 69 percent of suspected abusive and 76 percent of neglect families have had less than a high school education. The same is true for only 24 percent of accident and 36 percent of repeated accident families. Of all sources reviewed, only one (Elmer 1967*c*) reports no significant educational differences among the 31 abusive families in her study (10.1 years) and the general Pittsburgh population (10.0 years).

Because income, occupation, and education are all highly interrelated it is not surprising that, among reported cases, low-income, low-skill level or unemployed, and low-education families are overrepresented.

Age

Abusers are generally described in the literature as young, i.e., between 20 and 30 years of age at the time of the incident.[3] Lauer et al. (1974) found significant differences between the median ages of abusive parents (of 130 hospitalized, battered children at San Francisco General Hospital) and those of the comparison group (nonabused concurrent hospital admissions). Twenty-one percent of the abusive mothers and 9 percent of the abusive fathers were under 19 years of age; by contrast, only 8 percent of comparison group mothers and 1 percent of comparison group fathers were as young. The median ages for the four groups are as follows: abusive mothers = 22.5 years, abusive fathers = 25.2 years old; comparison mothers = 26.5 years, and comparison fathers = 29.0 years. Gil's (1968) survey yielded the following data: 37 percent of the fathers and 56 percent of the mothers were under the age of 30.

Not all abusers are under the age of 30, however. In Gil's survey of 6,000 cases, 20 percent of the fathers and 27 percent of the mothers were between the ages of 30 and 40. The sample

of 20 studied by Nurse (1964) included mothers ranging in age from 18 to 44 years and fathers from 19 to 51 years old. The median ages, in those cases, were 32 years for the mothers and 36 years for the fathers.

Young age at the time of marriage and at the birth of the first child are also mentioned as characteristics of abusive parents. Komisaruk (1966) notes that 32 percent of his sample of parents of 65 abuse cases attending a child study clinic were married before age 20. The average age at marriage for Sheridan's sample of 100 mothers on probation for neglect in England is 20.3 years. In the sample of parents of abused children referred to Smith, Hanson, and Noble (1973) for research, the average age of mothers at birth of the first child was 19.7 years, or 4 years below the national average. Sheridan (1959) reports the average age at first birth to be 19.3 years. Costin (1972) also comments on the young age of the abusive parent at marriage and birth of first child. However, comparisons with the national average tend to be misleading because, as already discussed, samples of abusive parents overrepresent low-income groups and these individuals tend to marry and have their first child at a significantly younger age than do individuals in higher-income groups. A more meaningful age comparison would be between the age at marriage and age at first birth of abusive and nonabusive low-income families. In other words, a relatively young (below the national average) age at marriage and at first birth is not characteristic of just abusive families but of the general population of low-income families from which these abusive families are typically drawn.

Family Size and Spacing

Large families are discussed in the literature as characteristic of abusive families. Light (1973) discusses this aspect of abusive families in depth; he compares statistics of abusive families in Gil's survey of legally reported incidents in the United States, a survey of abusers in New Zealand, and a National Society for the Prevention of Cruelty to Children survey in England with the family size distribution, as a whole, of families with children under 18 in those countries. He finds that the average family size for abusive families substantially exceeds the national average. For example, in each country, Light states that there are approximately 33 percent of all families with children under 18 years of age who have one child only. Abusive families in that category, however, amount to 18 percent in the United States, 23 percent in England, and 13 percent in New Zealand. A comparison of abusive families with the general population in the three countries in terms of percentage of families (with children under 18 years of age) who have four or more children can be seen as follows: United States = 39.5 percent abusive, 19.6 percent national average; New Zealand = 46.5 percent abusive, 14.1 percent national average; England = 12.9 percent abusive, 11.9 percent national average.

Light's analysis is confirmed by several other studies. Elmer (1967*c*) reports that the 31 abusing families she studied had an average of 3.7 children, while the general Pittsburgh population had only 2.6 children per family. The average number of children per abusive family in a study by Glaser et al. (1968) of 50 children hospitalized with failure-to-thrive is 3.8. Thirty-three percent of Johnson and Morse's (1968) sample of 85 families known to the Denver Welfare Department consisted of families with four or more children; 2 percent had eight or more children. Tormes compared the family size of 20 incestuous families with the size of 20 families in which children were sexually victimized by a noncaretaker. Both groups consisted of large families; however, the incest group had a family size median of 4.7 compared with a median of 3.9 for the nonincest families.

Data on family size were available at three of the programs we visited. In one, average family size was 4.6 in a sample of 45, in another the average family size was 1.8 in a sample of 74, and a third program reports an average family size of 2.6 in a sample of 101. These different rates reflect program characteristics rather than population characteristics. That is, programs which specifically seek out younger families with fewer children of course report smaller family size than do programs which seek out large multiproblem families. Therefore, data on family size are as much dependent on admission criteria as on any real events in the population of abusive or neglectful families. Data collected from these programs do indicate that abuse can very well occur in families with only one or two children.

Family size data appear to be confounded with SES data which were uncontrolled in the studies reviewed. That is, once again, comparisons with

national averages in terms of family size are misleading because low-income groups tend to have larger families. Based on 1973 U.S. Census data, the mean number of children per low-income family is 2.51 for caucasians and 2.99 for black families. The national average for the total United States population is 2.14.[4]

Another characteristic of abusive families reported in the literature is that children are usually born in close succession. From her study of 31 hospitalized abused children, Elmer (1967*c*) concludes that the most common combinations in terms of child spacing and abuse are 3 or more children with less than 1 year between birth of a sibling and hospital admission for abuse. Kempe et al. (1962) report similar findings based on their clinical observations and experiences.

Ethnicity

Noncaucasian families are overrepresented in some study samples. Gil's (1968) sample cohort of 1,500 abuse cases in 38 cities and counties across the country included 46 percent black families. Elmer (1967*c*), for example, compares her 31 hospital-referred families with the general Pittsburgh population. Twenty-seven percent of the sample is noncaucasian, 17 percent of the city population is noncaucasian. The Boston Children's Hospital Medical Center report (1974), using a sample of 311 inpatient cases, found that there were relatively more noncaucasian families in the abuse and neglect categories while accident and failure-to-thrive cases included relatively more caucasian children. More noncaucasians are represented in Holter and Friedman's (1968*a*) suspected abuse category (20 percent of a sample of 10 cases) and neglect category (80 percent of a sample of 10 cases), while the accident and repeated accident categories have 12 percent (of a sample of 34 cases) and 10 percent (of a sample of 33 cases) noncaucasians, respectively.

On the other hand, Heins' (1969) analysis of 164 abuse cases admitted to a Detroit hospital found more caucasian children abused than was expected. The ratio of black to caucasian abuse cases was 2:1 compared with the general hospital pediatric population of 3:1. Lauer et al. (1974) also found more caucasian children in their sample of 130 abused children in San Francisco General Hospital compared to their comparison group of concurrent (nonabused) hospital admissions. Caucasian children made up 37 percent of the abused sample; only 22 percent of the comparison group was caucasian.

The different proportions of noncaucasian abused can be understood as a function of what is used as a comparison group. Lauer et al. found that when comparing their sample with the census data instead of the comparison group, more noncaucasian children were abused. Ebbin et al. (1969) found a predominance of caucasian abused children in their sample of 50 children admitted to the Los Angeles County General Hospital. However, abused children were admitted for emergency treatment from the entire county while the study's comparison population (the hospital's pediatric outpatients) was drawn from the area immediately surrounding the hospital. Compared to the county as a whole, the immediate area has a greater proportion of black families. Therefore, the inpatient population which includes abuse cases has a higher proportion of caucasian patients than does the outpatient population from which the comparison group was drawn.

Five of the eight programs visited had data available on the ethnic status of abusive families and of the general population. In every instance, minority group members are overrepresented. Black families tend to be overrepresented in areas where there are black and Spanish-surname families, and American Indian families tend to be overrepresented in the areas in which they live. Because ethnic minorities tend to have relatively low incomes and because low-income groups tend to be overrepresented among abusive families, it is not surprising that ethnic minorities are overrepresented among abusive families. In any event, child abuse is certainly not restricted to ethnic minorities. In the programs visited, the range in terms of percentage of caucasian families referred to services was from 39 percent in one program to 85 percent in another.

Intact v. Single-Parent Status

The abusive families reported in the literature are characterized by a disproportionately greater number of female-headed households. Holter and Friedman (1968*a*) report that 32 percent (N=10) of the high-risk families (all abuse cases, some accident, and neglect cases) and only 12 percent (N=7) of the low-risk families (no abuse cases) were one-parent families headed by the mother. An even higher proportion (40 percent)

of 60 families were without a father or male guardian in the hospitalized population studied by Zuckerman et al. (1972). Thirty percent of the families included in a sample of 50 hospitalized abused children were intact, while this was true for 53 percent of the comparison pediatric outpatient population Ebbin et al. (1969). Based on her experiences and impressions, Costin (1972) also notes a high proportion of female-headed households.

Contradicting these findings is the report by Boston Children's Hospital Medical Center (1974) which stated that all 303 abuse families in their study had a father figure present in the home. DeFrancis (1963) found only 1 of 12 families to be one-parent households in his study of 328 cases reported in the newspapers. The sample used by Glaser et al. (1968) included 80 percent intact families out of a sample of 50 whose children were hospitalized with failure-to-thrive.

Gil (1970) also discusses family composition but relates it to ethnicity. In his sample of all reported incidents (approximately 6,000) in the United States, he found 20 percent of the children without a father or father substitute. Nearly one-fifth of the families had parents who were separated or divorced or the mother had been deserted or widowed. However, a substantial difference can be seen between the black, Puerto Rican, and caucasian families. There was no male present in 42 percent of the Puerto Rican families, 37 percent of the black families, and in less than 20 percent of the caucasian families. Since Gil's and most other samples are overrepresented in terms of noncaucasians and in terms of low-income families, the relationship between one-parent families and abuse is confounded in that it could be a function of the greater incidence of one-parent families in noncaucasian and low-income groups.

In most of the programs visited, single parent families are overrepresented among program participants as contrasted with the community in which the program is located. However, once again income and ethnic status are confounding variables. In 1973, the proportion of low-income families with female heads of household amounted to 63.8 percent of black families and 39.0 percent of caucasian families.[5]

In general, it can be concluded that income, occupation, education, ethnic status, single-parent status, age at time of marriage, age at time of first birth, and family size are all confounding variables. All of these variables are related to income and because low-income families are overrepresented in virtually all studies and all programs, possibly because of their greater visibility in the service delivery network, no causation should be implied. That is, it simply is not known to what extent, if any, any of these variables contribute causally to the problem of abuse.

Sex of the Abuser

There is no definitive answer as to whether abusers are more likely to be mothers or fathers. Green (1968), Lukianowicz (1971), Paulson et al. (1974), and Steele and Pollack (1974) all found the mother to be the abuser in the majority of cases studied. Lukianowicz found this to be true in 80 percent of the 18 cases studied in Ireland, and Paulson et al. in 55 percent of 31 families, of which 8 were single parent families. Steele and Pollack, finding the mother the abuser in 83 percent of 60 families, relate this to the low incidence of unemployment in their sample and to fewer hours of contact between the father and the infant than between the mother and the infant. Again, however, there is confounding in that a disproportionate number of abusing families are single parent, female-headed; thus, there are more mothers than fathers in a position to abuse. However, Glazier (1971) in a sample of 251 cases and Silver, Dublin, and Lourie (1971) in their sample of 24, found more cases where the father was the abuser. Other factors also come into play, however. For example, while Silver, Dublin, and Lourie state that the father was responsible for two times as many cases concerning children of all ages as was the mother, the mother abused children under age 2 three times as frequently as did the father. Glazier does not provide any statistics. DeFrancis (1963) found a greater number of fathers responsible for inflicting injuries in 662 abuse cases (38 percent compared with 29 percent for mothers), but more mothers (48 percent) were responsible for fatalities (22 percent for fathers). Johnson and Morse (1968) give the following breakdown of abusers in 85 families: mother in two-parent family (32 percent), father or stepfather in two-parent family (30 percent), mother in one-parent family (23 percent), both parents (6 percent), mother's boyfriend (5 percent), adoptive parent (3 percent), brother (1 percent). Paulson and Blake (1969) report that the sex of the abuser may vary with the sex of the child. That is, in

analyzing 96 cases, they found that although biological fathers were equally abusive to sons and daughters, mothers were more likely to be abusive toward their daughters.

In actual practice, it is often impossible to determine which parent was the abuser as often one parent is abusive while the other gives tacit approval or even encouragement. In many cases, even after a long-term treatment relationship has developed, it is still unclear as to who the actual perpetrator was. It does not seem that there is any real relationship between sex and abusiveness.

Our review of the literature on demographic characteristics highlights the fact that no conclusions can be drawn regarding the contribution of any of these variables to abuse and neglect. The highly interrelated nature of many of these variables suggests that only large-scale studies with sufficient sample size to control for each variable separately can provide a methodologically sound base from which to draw conclusions. Moreover, the practice of comparing abusive parents to national averages rather than to data on groups which are similar in demographic composition is highly misleading. Studies using census data on demographic characteristics which compare abusive parents with equivalent income groups are methodologically more sound than are studies which rely on comparisons between abusive parents and an actual comparison group drawn for the purposes of the study. The assumption that two people who use a service, e.g., a hospital, are comparable in all but their abusive practices is often misleading.

LIFE HISTORY CHARACTERISTICS

Alcohol and Drug Use

Thirteen studies report the incidence of alcoholism in a portion of their samples.[6] Generally, it is simply mentioned that alcohol abuse and drunkenness are prevalent, but percentages are not given. In a few publications more specific information is provided; however, no data are presented on the incidence of substance abuse in a comparable population of nonabusers. For example, in Johnson and Morse's (1968) sample of 85 abusive families referred to the Denver Welfare Department, 16 percent of the parents "drank to excess." Glazier (1971) reported intoxication as a circumstance of the abuse incident for 13 percent of the 334 abusive families studied. Glaser et al. (1968) report that 40 percent (N=16) of the parents of children hospitalized with failure-to-thrive exhibited family disruption or dysfunction which included alcoholism, among other traits, so that it is not reported in how many cases alcoholism is a specific problem. Drunkenness and drug addiction were among the characteristics by which 68 percent (N=23) of the cases studied by Silver, Dublin, and Lourie (1971) were known to the Women's Bureau in Washington, D.C. This unusually high percentage is likely to be a function of the particular referral source. Only a very small percentage (3 percent) of a sample of 293 parents whose children were reported to the New York City Bureau of Child Welfare were alcoholics or drug addicts (Simons et al. 1966). Nevertheless, these two traits are mentioned as factors contributing to an abusive situation by a number of authors whose work is based on clinical rather than research data. Some clinicians point out that abusive parents, trying to fulfill their needs through their children, use alcohol and drugs for the same purpose.[7]

Although most authors make no mention whatsoever of the presence of alcoholism or drug abuse, Smith, Hanson, and Noble (1973) specificially state that alcoholism and drug dependence were *not* present in their sample of 214 parents. This sample, however, is distinct from the others in that these families were referred by various consultants to the authors for the purpose of research.

Only one of the programs we visited maintains systematic data on alcohol and/or drug abuse. In this program, in 12 out of the 74 cases (or 16 percent) there was an alcohol or drug abuse problem. Staffs at other programs were asked to estimate the percentage of abusers with a history of drug or alcohol abuse. In each of the programs the variation from one staff member to another was as great, if not greater, as the variation from one program to another. In other words, in the absence of systematic data, these estimates were so subjective as to be considered totally unreliable.

History of Court Involvement

Prior history of involvement with law enforcement agencies among abusive adults is noted by a number of authors. However, these authors do not reference their findings to a comparable

population so that there is no information as to whether such a history of court involvement is particularly significant for abuse or not. Gil's (1968) nationwide study found that 8 percent of the mothers and 6 percent of the fathers of abused children had been involved in juvenile court, and that 5 percent of the mothers and 16 percent of the fathers had criminal records. Ebbin et al. (1969) report that 46 percent (N=23) of the battered children treated in Los Angeles County General Hospital had one parent with previous criminal convictions. Sixty-eight percent (N=23) of the mothers of abused children samples by Silver, Dublin, and Lourie (1971) were known to the D.C. Women's Bureau prior to the abuse incident for the following: support and custody, shoplifting, loitering, and assault. The only study discussing this aspect of the abuser's background which draws comparisons with a comparison group (Smith, Hanson, and Noble 1973) found that a "significantly" greater proportion of 134 abused children's parents (29 percent of fathers and 11 percent of mothers) had criminal records than did nonabusive parents of 53 children admitted to a hospital for emergencies other than accident and trauma cases. However, the proportion of nonabusive parents with criminal records is not given and so the meaning of the term "significant" is unclear.

None of the programs visited maintained systematic data on the abuser's history of court involvement. However, staff description of cases gave the impression that the history of many abusive parents includes involvement with juvenile, if not criminal, court.

Physical and Mental Disabilities

Physical disabilities or illness are mentioned as a characteristic of the abuser by a number of authors.[8] Based on 115 abuse cases described by social service agencies, Bryant et al. (1963) developed four abuser typologies, one of which concerns the physically disabled father (the other three types are related to personality). In such cases, the father is unable to support his family as a result of being disabled, which leads to financial problems as well as to additional tension from the father's more frequent presence in the home.

Gibben, in Blumberg (1964/65), found a history of major physical illness among one-third of the 39 imprisoned abusers in England. Bennie and Sclare (1969) found one-half of their 10 subjects to have some type of physical condition such as pregnancy or some disease aggravating their mental state. Gil (1970) found that 12.3 percent of the parents had been physically ill during the year in which the abuse occurred. Through their study of 87 children hospitalized for suspected abuse, neglect, and/or accidents, Holter and Friedman (1968*a*) found that in approximately 65 percent of the cases, a family member was seriously ill at the time of the incident which led to the child's hospitalization. Three-quarters of the parents had chronic physical and emotional problems.

As discussed in the literature, "mental disabilities" include low IQ and mental retardation as well as mental illness and emotional problems. It is difficult to determine how these diagnoses are made; that is, in most instances, no information is provided as to the tests or techniques used to establish a diagnosis.

Some authors cite characteristically low IQs among abusers, others describe their samples as having a wide range of IQ levels. Steele and Pollack (1974) found an IQ range of 70 to 130 among the abusive parents in the 60 families they studied. Helfer and Pollack (1967) also report a wide range of IQ scores among abusers. Despite the range, however, it seems that a disproportionately great number of abusers do reflect low IQ scores. Komisaruk (1966) points to 20 percent of the 65 parents he studied as having IQs of less than 75 and Gil (1968) found that 11 percent of the mothers and 6 percent of the fathers of reported abused children had deviations in intellectual functioning. Smith, Hanson, and Noble (1973) report a statistically significant difference between the two groups (abusers: XIQ=80, controls: XIQ=95). The sample consisted of 214 parents of 134 abused children referred to a research team compared with parents of 53 children who were nonabuse hospital emergency cases.

The presence of mental retardation among abusive parents is noted by a number of authors.[9] There are only three research studies of this variable and its relationship to abuse. Johnson and Morse (1968) report 9 percent of their sample of 85 families to have a mentally retarded abuser; a much higher 36 percent are "mentally disturbed." Morse, Sahler, and Friedman (1970) state that 78 percent (N=18) are mentally retarded and/or emotionally disturbed. Glaser et

al. (1968) found that 40 percent (N=16) of their families have some type of family disruption or dysfunction, among which mental retardation or illness is included. Because mental retardation is often subsumed under the more general category of emotional disturbances and mental illness, it is impossible to determine exactly what proportion of the abusers are diagnosed as mentally retarded.

While abusers are widely held to exhibit mental illness, emotional problems, personality problems, or defects in character structure, these terms are, however, rarely defined. An underlying assumption in the literature is that these characteristics predominate among abusers when, in fact, they are common among the nonabusing population as well. Very few comparisons have been made between abusers and nonabusers along such dimensions. Gelles (1973) further criticizes studies of abusers' mental health on the basis that they are essentially tautological: behavior is synonomous with explanation. For example, an abusing adult may be diagnosed as exhibiting poor emotional control and aggressive tendencies. The explanation given for abuse, however, is the same: aggression and poor emotional control. Because the behavior is synonymous with the dynamic, it is as impossible to ascribe causality to the dynamic as to the behavior. These caveats should be kept in mind during the ensuing discussion of the personality or mental disabilities mentioned in the literature.

Abusive parents in some studies had a history of psychiatric institutionalization. Gil (1968) reports that 7 percent of the mothers and 5 percent of the fathers of 6,000 reported abused children had been in mental hospitals prior to the abuse incident. Simons et al. (1966) report that, among 17 percent of 293 abusing families, one parent had a history of previous institutionalization in mental hospitals or penal institutions or had received treatment for mental or social problems. Fifty percent of the families had psychological problems which required counseling or social service support.

Using psychiatric, psychological, and social interviews, Smith, Hanson, and Noble (1973) compared 134 abusing parents with 53 parents of children who were hospitalized, on an emergency basis, for other than accidents and trauma. The authors found that a significantly greater proportion of the abusers (76 percent of the mothers and 64 percent of the fathers) exhibited "abnormal" personalities, further broken down into mild (character disorder), moderate (personality disorder), and severe (psychopathic). Significant differences were found at all three levels between abusers and controls. Sixty-two percent of the mothers and 26 percent of the fathers had mild or moderate disorders, 14 percent of the mothers and 37 percent of the fathers had severe personality disorders. None of the controls had personality disorders of a severe nature.

Using the Minnesota Multiphasic Personality Inventory (MMPI), Wright (1970) reports that the 15 abusive parents tested exhibited high scores on both the Psychopathic Deviancy (Pd) and Schizophrenic (Sc) scales. A high score on the Pd scale indicates impulsiveness, an easy appearance of social conformity, as well as an ability to manipulate. A high Sc score characterizes ego deterioration, breakdown of self-direction, feelings of isolation and inferiority. However, since the MMPI was given following the abuse incident there is no way of knowing to what extent those scores were influenced by the abuse and its subsequent detection.

Other literature dealing with the emotional status of abusers is less specific as to how the characteristics were determined.[10] Statements are simply made as to what proportion of the sample have mental or emotional problems. For example, Michael (1972) states that 25 percent of the mothers of abused children in his sample (28 cases hospitalized in Iowa) had identifiable medical and psychiatric problems prior to the reporting of the incident. Komisaruk (1966) reports eight mothers out of 65 families to be mentally ill. In Johnson and Morse's (1968) sample, 36 percent of the parents in 85 families were mentally disturbed and 4 percent were reported to be partially psychotic. Among the 10 families with children hospitalized for burns sampled by Holter and Friedman (1969) five mothers and five fathers were considered to be emotionally disturbed. Abuse was found in three of these families, situational crisis was determined in the remaining seven. Another study by Holter and Friedman (1968*b*) found that four fathers and three mothers in 18 families had received some form of psychiatric treatment. All 10 abusers studied by Bennie and Sclare (1969) were described as having personality disorders in terms of impulsive behavior. Depression was present in one-half of them. Delsordo (1963) classified 5 percent (N=4) of the parents he studied (cases referred to a SPCC) as mentally ill.

Despite the seeming prevalence of emotional problems, Kempe (1971) states that only 5 percent of abusing families include a psychotic parent, while an additional 5 percent are considered "aggressive psychopaths." The remaining 90 percent are characterized as "normal," but having problems in mothering. Generalizing from a very small study of 12 military families with an abused child, Cohen, Raphling, and Green (1966) found that the parents were immature, egocentric, demanding, and had a low level of frustration tolerance, but nevertheless were without psychologic or somatic evidence or clearly defined psychiatric illness. Spinetta and Rigler (1972) conclude that the literature supports the view that only a few abusing parents are severly psychotic.

Emotional problems or mental disabilities form the basis for constructing several typologies of abusers. For example, Merrill (1962), based on a study of 155 families known to the Massachusetts SPCC, constructs four types of abusers, of which three are personality derived. The three types are: (1) hostile, aggressive, (2) rigid, compulsive, lack of warmth, (3) passive, dependent. To these he adds a fourth unrelated type where the father is unable to support the family because of physical disability. Fontana (1973*c*) lists six types of abusers; they are: (1) emotionally immature, (2) neurotic or psychotic, (3) mentally deficient or uninformed about childrearing, (4) disciplinarians, (5) criminal/sadistic, (6) addicts. Polansky et al. (1972*a*) concentrate to a greater extent on personality traits. Their five types of abusers are: (1) apathetic-futile parent: passive, absence of interpersonal relationships, and verbal inaccessibility; (2) impulse-ridden: restless, aggressive, manipulative, unable to tolerate stress or frustration; (3) mentally retarded; (4) depressive: persistent sadness, indecisiveness; (5) psychotic: social withdrawal, bizarre behavior, severe anxiety, disturbances in stream of thought. Zalba (1967) bases his typology on the problem of control over abuse. "Uncontrollable abuse" includes (1) the psychotic parent, (2) the pervasively angry parent who expresses hostility through abuse, (3) the depressive, passive-aggressive parent who resents having to meet needs other than his or her own. The second classification, "controllable abuse" has three types. These are the (1) cold, compulsive disciplinarian who defends the right to discipline her/his children, (2) the impulsive but generally adequate parent with marital conflict, where feelings toward the spouse are displaced onto the child, and (3) the parent with an identity/role crisis where the person is unable to cope with role changes necessitated by external factors such as physical disability.

The studies in this area suffer from lack of data on the incidence of various physical and mental problems in the population at large and from lack of definitional clarity.

The programs visited do not collect systematic data on history of mental illness and hospitalization and most report knowledge of such a history with reference to a relatively small proportion of of cases. However, as a clinical psychologist listening to individual case presentations dealing with more than 80 families and attending staffings on at least another 30 cases, it is the senior author's impression that in the large majority of instances these are individuals with severe ego impairment. The total group of cases represents a composite history of suicide attempts, brief hospitalizations, major impairments in interpersonal relations as manifested by a lack of friends and a multiplicity of transitory emotional entanglements with adults who are physically abusive not only with their children but also with each other, distortions in reality testing, impairments in thinking or functional retardation, problems with impulse control, immaturity and lability of affect, and a marked tendency to rely on projection and denial as major defense mechanisms. It must be said that a large proportion of the cases described manifest severe psychopathology.

DYNAMIC CHARACTERISTICS: THE DYNAMICS OF ABUSE AND NEGLECT

In the discussion which follows, the individual explanatory constructs which, in addition to the structural problems discussed above, comprise the dynamics of abuse are organized under the following headings:

- child-related knowledge, attitudes, and behavior
- childhood experiences and role modeling
- relationship stress
- self-concept: feelings of helplessness and mistrust of self and others
- isolation

Child-related Knowledge, Attitudes, and Behavior

The abuser's attitudes toward children are used as descriptive or explanatory constructs by many authors. These attitudes revolve around two questions posed by Kempe (1971). He asks: "How does the parent see the child?" and "How much and what do they expect of the child?" In answering the first question, it is generally agreed that abusive parents see their children as small grown-ups capable of adult thinking. These parents view their children as if they were older than their chronological age.[11] They lack the understanding that infants and children have special needs of their own and that they require nurturant care.

In answering the second question, the parents' behavior toward the child consists of demanding a high level of performance. Expectations are not age-appropriate, instead they are geared to the needs and unrealistic, preconceived expectations of the parents.[12] Describing the parent's behavior toward the child, Steele and Pollack (1974) state that ". . .not only is the demand for performance great, but it is premature, clearly beyond the ability of the infant to comprehend what is wanted and to respond appropriately. Parents deal with the child as if he were much older than he really is . . . the parent feels insecure and unsure of being loved, and looks to the child as a source of reassurance, comfort, and loving response" (p. 95).

In Elmer's (1967) study, abusive mothers felt that too much attention to infants is harmful and described a "good" baby as obedient, grateful, and respectful. She also found that a majority of abusive mothers think that babies should know right from wrong at 12 months of age; one-third of the mothers felt such understanding should take place by 6 months of age.

Ignorance of child care techniques is another characteristic of abusive parents. Lacking skills necessary to function as adults and parents, they are ill at ease and derive little satisfaction from the parental role. None of the mothers of 40 children hospitalized with failure-to-thrive studied by Evans, Reinhart, and Succop (1972) had a sense of fulfillment in their parental roles. Mulford and Cohen (1967) rated the parents of 959 families known to a social service agency in terms of child care. Forty-six percent were rated poor regarding their children's education, 47 percent were poor caretakers in general, and 56 percent were rated poor disciplinarians. Holter and Friedman (1968*a*) state that one-fourth of the mothers of 87 hospitalized children classified as abuse, neglect, and accident cases experienced difficulty in fulfilling the parental role because of hyperactivity, ineffective disciplinary means, and a lack of understanding of child growth and development.

Ignorance of alternative disciplinary methods can result in the imposition of severe punishment for all childhood infractions.[13] Disciplinary abuse was found by Delsordo (1963) in 15 percent of the 80 cases handled by an SPCC. In these incidents, the parent committed abuse because the child did not comply with parental expectations. Among 54 abused children, Friedman and Morse (1974) found that the vast majority of parents relied on physical punishment as the means of child care. Fontana (1973*c*) divides the disciplinarians from unknowledgeable parents. He states that some parents are: ". . . living out our national belief that physical punishment is a legitimate method of childrearing, possibly the most effective way of compelling obedience" (p. 69). Others are not able to learn about child-rearing or are unable to reason through crises.

The parent's personality traits are also factors in the perception of the child. Melnick and Hurley (1969) and Polansky, Hally, and Polansky (1974) describe abusive and neglectful parents as being deficient in their ability to empathize with, and minister to, the needs of their children. Polasky, Hally, and Polansky also consider this "coldness" to be characteristic of mothers with failure-to-thrive children. Based upon their observations of abusive/neglectful parents during the hospital admission process, Morris, Gould, and Matthews (1964) state that the parents do not volunteer information but are, instead, evasive and self-contradictory. They appear irritated when asked about the child and maintain that the injury was self-inflicted. They are critical of the child and show no indication of guilt. Their behavior at the hospital indicates a total lack of concern for the child in that they leave either during the examination or soon after, visits are infrequent, and there is no interest shown in the child's discharge or followup care.

The parent's "impoverished" personality cannot handle a child-nurturing relationship. The parent tries to meet his or her own dependency needs first; in a striking role reversal she/he tries

to involve the child in the gratification of the parent's dependency needs.[14] Infants are perceived as having adult powers to displease or judge their parents. If the child does not fulfill this role but acts according to his age, the parent becomes disappointed, distraught, and frustrated, and reacts by abusing the child. The fact that the child is unable to behave as expected is seen by the parent as both rejection and accusation of failure.[15] "Misplaced abuse," where the parent's conflict is projected onto the abused child, accounts for over one-half of the 80 cases studied by Delsordo (1963). Corbett (1964) also finds that a parent's hostility becomes dangerous when the child is of a specific age relating to factors in the parent's conflict. For example, a 4-year-old child may remind the parent of an event that occurred when the parent was that age. Polansky et al. (1972*b*) found, in their study of 10 mothers, that good mothering did occur when the child was helpless and attached. As the child grew older and more independent, however, the mothers could no longer handle the child-rearing situation. Thus, some parents are unable to tolerate the dependence, helplessness, or the messiness of the infant; others are unable to tolerate the moves toward independence of the toddler.

In somewhat parallel fashion, but because of either specific fantasies or the particular life situation of the parent, the child may be viewed as a competitor, as "bad" or seductive, as unwanted, or in some other way as being different from other children. The parent may identify the abused child with a hated person or situation. For example, the child may remind the parent of one of his/her parents with whom the relationship was especially devastating. The unplanned for or unwanted child may be seen as a burden or source of irritation by the parent who must care for him. Similarly, a stepchild may be regarded as unwelcome by the stepparent who sees the child as a reminder of the spouse's former marriage which is resented.[16]

It has been suggested that there may be a relationship between the sex of the abuser and the sex of the abused. In other words, if the child represents to the parent a hated aspect of that parents own self as a child, it would be expected that mothers might be more likely to abuse female children with whom they identify and fathers would be more likely to abuse male children. Children's Trauma Center data on 61 cases on this point show that there is absolutely no relationship between the sex of the abuser and the sex of the abused.

While it seems clear that unrealistic expectations, lack of knowledge of child development, and an idiosyncratic view of the child based on the parents' needs and experiences are indeed characteristic of abusive parents, little is known about how prevalent these characteristics are in a demographically comparable nonabusive population. This suggests the need for normative data as to what people in general expect of infants and small children and the degree to which physical punishment is considered to be useful and acceptable. In an earlier study (Holmes, Holmes, and Greenspan 1973) of 354 low-income families in seven different communities we found that a very high proportion of mothers have unrealistic expectations of children in terms of age at which children can be toilet trained. Moreover, hitting and other physical punishment of small children, including toddlers, for such a minor infraction as throwing food out of a high chair, or as a way of socializing children not to hit other children are relatively high on the response hierarchy.* Thus it seems that while unrealistic expectations and lack of knowledge about alternative means of coping with child behaviors may be typical of many abusive parents they are also typical of many nonabusive parents. This suggests that pediatricians and nurses in well-baby clinics and in hospitals should be encouraged to ask the mother about her expectations for the child and about her beliefs and practices so that deviant and mistaken expectations, beliefs, and practices can be identified and, in some cases, corrected through the provision of accurate information. While, as discussed in the next paragraph, such efforts at prevention have their limitations, there are parents who can be reached through such an approach.

Unrealistic expectations based on parental dependency needs and lack of knowledge of alternative means for discipline and of child development are universally seen by staff in the programs visited as extremely important contributors to child abuse. However, an important distinction must be made between those who see

* Seventeen percent of the mothers felt that babies should be toilet trained at 10 months or younger and an additional 26 percent felt that this should be accomplished by 14 months of age; 14 percent of mothers reported they would hit the baby to get him to stop nuisance-like behavior; 26 percent reported that they would hit a toddler who hit another child in order to teach the toddler not to hit.

lack of knowledge of child development and of discipline alternatives as a cognitive problem requiring an educational approach and those who see unrealistic expectations and harsh discipline as an outgrowth of the parents emotional needs, requiring a therapeutic approach. Staff in most programs believe that both cognitive gaps and emotional deficits are operative but there is considerable variation in emphasis. Programs which stress the emotional problems, primarily intense unfulfilled dependency needs, tend to place an emphasis on meeting the dependency needs and state that education cannot begin until these needs are at least partially met. In several programs, staff has tried parent education classes only to discover that their efforts at education fall on deaf ears because of the enormous feelings of emotional deprivation on the part of the parents who need to talk about themselves rather than about their children. By and large, the consensus seems to be that education about children and their needs can only "take" after an initial therapeutic relationship has been established and some of the parent's concrete and emotional needs have been met. Once the parent's needs have been at least partially met, the parent is more able to focus on the separate needs of the child.

Staff working with abusive (rather than neglectful) parents often note that the child is so important to the parent that getting the parents to leave the child in day care or with a babysitter is often a major therapeutic accomplishment. Staff speak of the void which parents feel within themselves, of an enormous emptiness which is filled only by the child. In general, abusive parents are not characterized as indifferent to their children, but rather as desperately and pathologically overattached to them. Their inability to see the child as a separate individual with needs of his own represents a kind of insensitivity which may appear as indifference but is actually overidentification. Far from having given up or withdrawn from the child, the abusive parent strives for the perfection of the child as a reflection of her/himself and as a need-gratifying object. Descriptions of parental withdrawal from hospitalized abused children may seem to contradict this picture of parents who are overly fused with their children, but this overt behavior on the part of the parents is in response to their feelings of guilt, fear, and anger rather than as a reflection of the degree of their attachment to the child.

Childhood Experiences and Role Modeling

Childhood experience, the way in which the parents were reared, is described by many authors as one critical factor in the potential to abuse. A considerable number of parents report that they were, themselves, abused as children.[17] Gil (1970) found that at least 14.1 percent of the mothers and 7 percent of the fathers of approximately 6,000 legally reported abused children in the United States had been abused in their own childhood. Helfer (1975) describes this cycle of child abuse and neglect in terms of his concept of a "world of abnormal rearing" (W.A.R.). "W.A.R. children have experienced some negative and detrimental happenings during their childhood, affecting them in many ways resulting in a variety of presentations to professionals, child abuse and/or neglect, being only two of the many 'spin-offs' from this abnormal rearing cycle" (p. 26).

Galdston (1971*a*) also states that particular attributes of the child (age, sex, position in family) correspond to events in the parents' early lives. Paulson et al. (1974) write that the parents' early childhood fears are displaced onto the child. Bennie and Sclare (1969) state that a childhood event in the parents' history or fears of the parent's parent centers around a child. For example, Komisaruk (1966) found in his sample of families that 69 percent (N=25) of the mothers and 60 percent (N=17) of the fathers suffered an emotional loss of a significant parental figure in their early childhood. The Boston Children's Hospital Medical Center (1974) study findings strongly support the view that disruption in the abusive mother's family of origin is associated with abuse. Similarly, there was a statistically significant difference between the number of geographic moves made by these mothers and by control mothers in childhood. Both of these findings point to a high degree of disruption in childhood. Evans, Reinhart, and Succop (1972) relate the breakdown of mothering in their sample of mothers of children hospitalized with failure-to-thrive to the experiencing of a severe object loss. All mothers in their group I (N=14), characterized by depressed economic status but good living conditions, small families, and young mothers, had a loss, e.g., death of own mother, within 4 months of the first hospitalization of the child.

In any case, the deprivation, indifference, rejection, and hostility experienced in early childhood raise the level of hostility in the child and act as a model of behavior for the time when that child becomes a parent. The abusive parent treats his child as he/she was treated in childhood.[18] Steele and Pollack (1974) state that "without exception in our study group of abusing parents, there is a history of having been raised in the same style which they have recreated in the pattern of rearing their own children" (p. 97). Early role modeling such as this is fixed by experience; later relationships or observations, according to Morris and Gould (1963), do not seem to change the pattern. Fontana (1973c) has stated that the parent's ". . .own upbringing and background have distorted their personality, attitudes, and values and left them unprepared for parenthood" (p. 64-65). An absence of parenting or "poor mothering," defined by Steele and Pollack (1974) as ". . .a lack of the deep sense of being cared about from the beginning of one's life. . .," leads to the lack of a role model for effective parenting (p. 98).

Almost universally, program staff reports that the abusive parents known to them were abused, raised in foster homes, or lived in an atmosphere characterized by harsh criticism and lack of support and nurturance. Virtually without exception the parents described during our site visits had histories of abuse, criticism, severe rejection, and an absence of nurturing role models.

It is a striking paradox that despite these emotionally unsatisfactory relationships, in the programs visited it was reported that a large proportion of currently abusive parents maintain intense ties which can be characterized in terms of hostile symbiosis to their own parents at whose hands they experienced such abuse, deprivation, and criticism. In a striking number of cases, parents and grandparents live within a few blocks or a few miles of each other and despite the pattern of destructive criticism and tearing down are unable to separate from each other. It seems clear that many abusive parents are engaged in a never-ending effort to attain the approval and nurturance they never received in childhood.

The Lehigh-Northampton program described in part I has gone so far as to rule out all grandparent placements on the grounds that the relationship between parents and grandparents is typically so destructive that the child merely becomes another issue and pawn in this life-long struggle. Similarly, Helfer (1975) has pointed out that "more often than not, the relatives have a negative influence on the parents and their incorporation in the treatment program should be very carefully planned if at all possible. Having a maternal grandmother care for the baby while the mother is learning some of the skills that she missed as a child may well be detrimental, since it is this very same grandmother who had difficulty in rearing the child's mother when she was small" (p. 40).

While there is general agreement that abusive parents were themselves treated with hostility and lacked nurturant care in childhood there is virtually no empirical substantiation of the often repeated view that abused parents were themselves actually abused as children. Gil's (1970) study which found that 14 percent of the mothers and 7 percent of the fathers report themselves to have been abused as children represents the only evidence on this point. Based on these figures it cannot be said that a majority of abusive parents were abused as children. In the absence of normative data it is impossible to determine the extent to which a childhood characterized by hostility and lack of nurturance is particularly characteristic of abusive parents.

Relationship Stress

Marital differences among abusive families, characterized by repeated separations and family tensions, are noted in a number of studies.[19] Johnson and Morse (1968) report severe marital conflict for over 70 percent of the 85 families in their sample. Merrill (1962) notes that 40 percent of 115 families had marital problems. However, Simons et al. (1966) comment that the proportion of discord or separations recorded for 293 abusing families in their sample was not strikingly different from the proportion among the general population groups from which the families came. Elmer (1967c) also found marital problems among abusers and nonabusers but concluded that abusive couples handle their problems by means of quarreling and separations, whereas nonabusive couples quarrel but tend not to separate. Several authors also note that abuse may occur between the spouses themselves.[20]

Kempe and Helfer (1972) ask the question: Is the abuser's spouse so passive that he or she cannot give? The authors view an inability of the spouse to give as one factor contributing to the

potential for abuse. Several authors report the emotional unavailability or passivity and compliance of the spouse.[21] Implicit in this conceptualization is the suggestion that both parents are involved in the abuse: One parent perpetrates the injury while the other parent keeps silent and in doing so lends passive support to the actively abusing parent. The parents of the abused child protect each other rather than the child. Often the marriage is based on desperation, dependency, and a "clinging" out of fear of loneliness.

Relationship stress, which is defined by staff in the programs visited in terms of stress between two members of a psychological, if not legally married, couple, is reported almost universally. However, there is disagreement as to whether or not the stress is characterized only by emotional unavailability and lack of mutual gratification or also by aggressiveness and physical abuse between the members of the adult couple. Steele and Pollack (1972) report that abusive couples are not characterized by aggressiveness toward each other. In the programs visited, a large proportion of the couples described are characterized by physical abuse of the women. In fact, several public health departments reported their view that residences should be set up for women who have been so severely beaten by their male partners that they cannot return home for a period of time. Children's Trauma Center reports that physical abuse of the spouse is characteristic of 20 percent of their abusive families. Where there is no apparent physical abuse, relations are characterized by an inability to communicate, share concerns, provide mutual support and companionship, and to enjoy mutual leisure time activities. Faced with unending disappointment, relationships are punctuated by numerous separations, fleeting relationships with others, and remarriages. In many cases the fear of abandonment leads to excessive demands and quarrels with the result that, as part of a self-fulfilling prophecy, the spouse sets her/himself up for the abandonment which is so desperately feared. In many cases, the clinging symbiosis which characterizes the relationship between parent and grandparent and between parent and child also characterizes the relationship between male and female partners so that despite the destructiveness of the relationship they remain together.

While there is a consensus that relationship stress is characteristic of abusive parents, it should be pointed out that such stress is endemic to our society and is therefore not a distinctive characteristic of abusive parents. Gelles' (1972) research shows that intracouple violence in our society is a rather large problem. It may well be that the degree and pervasiveness of tension and hostility in the context of acute dependency needs is peculiar to abusive couples but in the absence of normative data such a conclusion is unwarranted.

Self-Concept: Feelings of Helplessness and Mistrust of Self and Others

Low self-esteem, self-hatred, fear of rejection, and low frustration tolerance are reported to be characteristic of abusive parents.[22] Abusive parents are described as especially sensitive to and fearful of criticism and abandonment, particularly by the spouse, and require constant reassurance to combat feelings of insecurity and feelings of being unloved.[23] However, Komisaruk (1966) states that while needing a great deal of assistance in managing their day-to-day living, the 65 abusers he studied had an inappropriately high evaluation of themselves.

Barbero, Morris, and Redford (1963) and Evans, Reinhart, and Succop (1972) discuss mothers of failure-to-thrive infants in terms of their problems in maintaining self-esteem. These mothers are unsure of themselves and strained in their handling of the infants. The mother is frequently unable to find something of value in the child that she values in herself. It is not until self-esteem is fulfilled that the mother is able to nurture her infant. Barbero, Morris, and Redford (1963) state that ". . .identification of the newborn baby as part of a mother's good self-image is a process and condition necessary to the physical and mental health of the mother-baby unit" (p. 14).

Green et al. (1974) view projection and externalization of feelings as the parents' responses to assaults on their fragile self-esteem. Thus, if a crisis occurs or events simply do not go as expected, feelings of inadequacy and lack of control may lead to abuse.

All programs report that lack of self-esteem is universal among abusive parents. Program staffs describe abusers as individuals who are incapable of saying or feeling that anything about them is good. As a function of the identity fostered by their hypercritical or abusive parents, they see themselves as worthless and experience their

own abusive behavior as conclusive proof. Most staff at the programs visited report that low self-esteem is a problem in 90 to 100 percent of the parents with whom they work.

Isolation

The literature points to the isolation of these families; they do not have the external resources necessary to deal with the many stresses with which they are confronted.[24] Holter and Friedman (1968*a*) found that 70 percent of 30 families designated high-risk (all suspected abuse cases, some neglect, some accident cases) were socially isolated as contrasted with 53 percent of the 57 low-risk families (no suspected abuse cases). However, this difference is not statistically significant ($x^2 = 2.44$, ldf). Paulson et al. (1974) report that in their sample of 31 families referred to a group psychotherapy program, a considerable number were without telephone or car. However, they present no data on the number of such families nor on the absence of these commodities in a comparable group. Kempe (1971) reports that abusive parents lack any means for a rescue operation from friends in times of crisis.

It is reported that abusive parents often have poor relationships with their own parents and with other relatives. In general, they cannot count on support from family members when it is needed, such as during pregnancy and child-rearing, and in financial or other crises.[25] Giovannoni and Billingsley (1970) emphasize the impoverishment of relationships between neglectful parents and their extended kin. However, those families designated "potentially neglectful" (not recognized by community agencies as neglectful but who nevertheless have problems in all areas, e.g., poverty, housing, mental stress) were noted for their extensive neighborliness.

Isolation from the community is also a characteristic of abusive families. They have few ties outside of the home and are not affiliated with church, PTA, or other social or recreation organizations.[26] Wasserman (1967) terms the lack of community participation a "community exclusion." Neglectful parents have also been found to be uninformed about formal community systems and are reported to be underrepresented in auxiliary community programs directed at the poor.[27] Polansky et al. (1972*b*) relate the neglecting family's fear of leaving home and attending groups, clinics, etc., to a separation anxiety concerning the family and family-owned land. Seven of the ten neglectful families they studied lived close to their mother or mother-in-law, lived on family-owned land, and, in general, appeared to have a symbiotic relationship with family members.

Elmer (1967*c*), in her followup of 31 families whose children had been hospitalized for abuse, states that a ". . . lack of association with a church, in conjunction with a lack of other outside associations, was found to be typical of abusive mothers" (p. 21). Merrill (1962) and Bain (1963) report that 50 percent of the 115 SPCC referred families had no formal group associations, 28 percent belonged to one association, most often the church. Eighty-five percent of Young's (1964) sample of 180 families designated severe and moderate neglecters and severe and moderate abusers were not members of any organized group. No religious affiliations were found for 68 percent of the severe abuse, 69 percent of moderate abuse, 70 percent of moderate neglect, and 91 percent of severe neglect families. Only 2 out of 10 suspected abuse families whose children were seen in a hospital emergency room had contacts with social groups (Holter and Friedman 1968*a*). A distinction was found by Mulford and Cohen (1967) between participation in adult activities and child-centered activities. Eighteen percent of 959 families participated in adult-centered groups, 41 percent of the families had membership in child-centered organizations. Religious organization affiliation was low at 11 percent.

Geographic mobility also results in social isolation and stress. Holter and Friedman (1968*b*) state that abusive families are frequently new to a community and have no friends or relatives to call upon in that community. Lauer et al. (1974) compared 130 hospitalized abused children with 130 nonabuse hospital admissions in terms of mobility. Statistically significant differences were found in the length of time each group had been at their present address. Sixty-six percent of the abusing families, but only 42 percent of the controls, had been at their latest address for less than 10 months. Only 5 percent of the abusers had an unchanged residence for 30 months or more, while this was true for 20 percent of the control families. The Boston Children's Hospital Medical Center (1974) report found statistically significant differences between abusive and control parents in that abusive

parents were more likely to have made two or more moves in the year prior to the incident. Mulford and Cohen (1967) report that one-third of their sample of 959 families had moved more than once in the preceding 2-year period. Tormes, in her study of 29 sexual abuse cases from records of a SPCC, found more foreign-born mothers and less exposure to New York City life among families where incest occurred than among the comparison group of families of children who were sexually victimized by a nonblood-relative. One study differs on the aspect of geographic mobility, however. Merrill (1962) states that most of his sample of 115 families had lived in their neighborhoods for years; nonetheless, there was still a lack of integration with the community, as cited earlier.

Social isolation is associated with mobility, poverty, and social structure. In addition, it is also likely to be a function of feelings of low self-esteem, of resultant fear of rejection by, and mistrust of, others, and a massive defense against unmet dependency needs. Social isolation is considered by virtually all programs visited to be an almost universal factor in child abuse.

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Unrealistic expectations of children; a history of abuse, severe criticism, and absence of nurturing relationships in childhood; relationship stress; poor self-concept; and social isolation are the factors which together make up part of the clinical assessment kit bag of the intake interviewer who must initially decide whether the injury to the child was accidental or not. In virtually all programs visited with a clinical orientation, once initial questions have been asked about the injury itself, the next set of questions is designed to assess the parents' relationship to the child, the parents' history of relationship with his/her parents, the parents' feelings about her/himself, the quality of the couple relationship, and the availability of a supportive network.

In most programs, these are known as the "dynamics of abuse" and when they are all present (along with certain other factors to be discussed later, e.g., the crisis), despite a possible inability to prove that the injury was nonaccidental, programs will designate such families as high-risk and will make every effort to work with these families. As one program director put it, "...when the dynamics are there, even if we can't prove how the injury happened and even if the parents don't want to work with us, we keep going back and trying to offer some help because you just can't afford to ignore those dynamics."

The question must be raised as to how convincing these "dynamics" are in light of the fact that individually they are unsupported by any solid research findings. Nevertheless, when taken together they seem to represent a clinical syndrome which, while it has not been substantiated with research, does seem to hold up in practice. Ultimately, substantiation for these dynamics will have to come through more carefully designed research which includes comparison groups and careful measurement not only of the presence or absence of the dynamics but also of their pervasiveness and their interaction with each other.

EXPLANATORY THEORIES

In addition to the individual constructs and dynamics of abuse which have been discussed, many authors have organizing theories of abuse and how it occurs.

The literature in this area stems from two different orientations which are used separately by some authors and jointly by others in explaining abuse. Psychological explanations which rely on personality characteristics of the abusive caretaker and the abused child constitute one body of theory. The second orientation, which relies on sociological/environmental explanations, makes assumptions about abuse that are based on family structure and dynamics, family living situation, and societal pressures. Both views include life stresses and individual inability to handle them, but sociological explanations place greater emphasis on the stress factor while personality traits or defects are considered more important in psychological explanations. Some authors favor one orientation over the other; a larger number, however, assume that both explanations are valid and discuss them jointly. The nature of each explanation is discussed separately below. Following this is a review of the works which are based on a combination of approaches.

Psychological Explanations

A psychological orientation toward child abuse is taken by several authors. For example,

DeFrancis (1963) finds "emotional immaturity as probably the greatest single cause for destructive behavior" (p. 9). The parent is unable, because of immaturity, to cope with situations and stresses that occur generally throughout society. Criswell (1973) also assumes that abuse is a result of anger and frustration owing to a crisis or to some situation which the parent cannot handle. Holter and Friedman (1969) emphasize the emotional disturbances present in families of burn victims as well. They found a high incidence of psychopathology within the three abusive family units and among the seven families where the incident was classified as "situational crisis."

Gelles (1973) criticizes the psychological approach as being too narrow and inconsistent. It is based on one causal variable (personality defects or aberrations) while at the same time a great deal of the literature states that all abusers do not have severe disturbances.

Sociological/Environmental Explanations

Sociological explanations generally are based on the particular situational circumstances in which the family exists and on a precipitating crisis. Mitchell (1973) states that " . . . abuse or neglect of a child frequently is due, not to malice, but to the fact that parents are overwhelmed by their life circumstances" (p. 480). One context refers to stresses associated with childbirth and childrearing; the birth of an unwanted child or short birth intervals are seen as precipitating factors.[28] Rose (1961) lists 14 specific critical stresses associated with a breakdown in mothering which may occur singly or in combination. Most of these are pregnancy-related stresses. They are: (1) multiple births, (2) children born within 10 to 12 months of each other, (3) previous abortions, sterility periods, traumatic past deliveries, loss of previous children, (4) conception with a series of devaluating experiences, (5) loss of husband or infant's father close to prenatal period, (6) pregnancy-health complications, (7) dislocating moves during pregnancy or the new-born period involving changing geographic areas, (8) marital infidelity discovered in the prenatal period, (9) experience with close friends or relatives who have had defective or injured children, (10) illness of self, husband, or relative who must be cared for at a critical period, (11) unexpected loss of security, (12) moving away from the family group and back to it for economic reasons at a critical period, and (13) role reversals.

Stress generated by other situations is also seen as a precipitator of abuse. R. C. Smith (1973) and Costin (1972) list loss of employment or lack of financial resources as one factor. Poverty and neglect are linked by Giovannoni and Billingsley (1970) who state that " . . . poverty exposes parents to the increased likelihood of additional stresses that may have deleterious effects upon their capacities to care adequately for their children" (p. 204). Giovannoni (1971) differentiates neglect from abuse in that she thinks the latter is less directly linked to environmental stress produced by poverty. Abuse is more related to interpersonal and intrapsychic difficulties than is neglect but this is further qualified by her linking of poverty and psychological disorders.

Light (1973) criticizes the reliance on these sociological variables because they do not discriminate between abusive and nonabusive families. Abusive families are characterized by unemployment, large family size, and social isolation, but not all families with these characteristics abuse their children. Gelles (1973) adds that it is necessary to explain why abuse and not another response occurs as an adaption to stress. The sociological explanation detailed above does not do this. Wasserman (1967) concludes that a sociological explanation is insufficient and inadequate because these sociological factors are not exclusive to abusive or neglectful parents. In his view, sociological factors leave out the intense fears of closeness, the low self-esteem, and the use of the child as a projection of the parents' own needs.

Some authors relate abuse to particular societal values. Caffey et al. (1972) feel that the value placed on mother love and the belief that all women need children for fulfillment is overemphasized. The conflict between stressed values and ability to practice them leads to abuse. DeCourcy (1973) also discusses the difficulties associated with the expectation that women will marry and have children in the context of decreasing familial support and guidance: extended families are less common and families are more mobile, both of which lead to social isolation. Gil (1971*a*) and Prescott and McKay (1974) discuss the encouragement of the use of physical force within society. Abuse is

physical punishment, which is accepted in childrearing, taken to an extreme.

Sociopsychological Explanations

Most authors subscribe to the view that both sociological/environmental and psychological factors contribute to abuse. As Gil (1970) states, " . . . physical abuse of children is not a uniform phenomenon with one set of causal factors, but a multidimensional phenomenon" (p. 125).

Green et al. (1974), Helfer (1973), and Lascari (1972) all describe three components needed for abuse to occur. They are: (1) the potential for abuse: the parent's personality attributes that contribute to "abuse proneness" (Green et al.), how they are reared, their self-image, ability to use other people, their marital relationship (Helfer; Lascari); (2) characteristics of the child that increase the likelihood of abuse: and (3) a crisis, series of precipitating factors, or immediate environmental stresses that make childrearing especially difficult for the parent. Examples of environmental stress, as provided by Green et al., are lack of childrearing resources due to spouse's illness or unavailability of caretaker, loss of a key relationship, additional pressures from a newly born child, and illness of other children in the family. An example of the second component, characteristics of the child, may be preexisting mental retardation or low birth weight which causes isolation of the child from the mother in the neonatal period.

Polansky, Hally, and Polansky (1974) discuss sociological/psychological factors leading to neglect. The sociological components are stress resulting from poverty and economic need, lack of meaningful standards and values in child care and child treatment, and breakdown of the nuclear family because it cannot provide all the support from within that is necessary. Parental pathology of various kinds provides the necessary psychological component. The authors approach neglect from a psychosocial view with life circumstances scarring the parent's personality. The person is then less able to tolerate additional hardships and stress and becomes even weaker. In other words, there is a feedback process in operation; personality and life stresses interact and affect each other.

The report by the Boston Children's Hospital Medical Center (1974) approaches abuse and neglect from a temporal view. They divide stress into two types: historical and contemporaneous. Historical stress, such as broken families, geographic mobility, history of violence, ill health, physical problems, mental illness, drug dependency, and alcoholism, occurs in the life of the caretaker up to the time of conception of the child. Contemporaneous stress is that which takes place at any time after the conception of the child. It also includes family, marital, and environmental stress, such as housing problems, unemployment, ill health, death or recent breakup of a significant relationship, unwanted children, family friction, and absence of external family supports. Comparing abuse cases with accident cases with respect to the presence of these two types of stress, the authors found that while both populations had high levels of current stress, historical stress in the mother's family of origin was absent among accident families.

In several publications (1969, 1970, 1971*a*, 1975), Gil has discussed the forces which contribute to child abuse. One force is environmental chance where accepted disciplinary measures become unacceptable when taken to extremes. Environmental stress factors are another force. These are "triggering contexts" which weaken psychological mechanisms of self-control and lead to aggression. The third force is deviance or pathology in physical, social, intellectual, or emotional functioning on the part of abusers or abused children. Fourth are disturbed intrafamilial relationships involving conflicts between spouses and/or rejection of individual children. All of these forces interact; psychological disturbance, according to Gil, is rooted in and interacts with forces in the social environment. Thus, he states that " . . . child abuse may be causally related to a varying combination of forces which emanate in part from the social environment and in part from pathological group processes and individual psychopathology" (Gil 1966, p. 63). He also takes the position that the difference between abusers and nonabusers is one of degree; there are no absolute qualitative differences between them (Gil 1968).

Gil, as mentioned in the section concerning sociological explanations, discusses the importance of the societal attitude toward the use of force as a legitimate means of attaining one's ends. Childrearing in the United States does not exclude the use of physical force; there are no

clear sanctions or prohibitions against parent-child violence.

Gelles (1973) delineates a social-psychological model of the causes of child abuse with a number of factors acting upon each other. These factors are the social position of the parents (age, sex, socioeconomic status), their socialization experience with regard to aggression (whether they were abused as children, their role models of violence), the parents' psychopathic states (personality and character traits, poor control, neurological disorders), and their class and community values and norms of violence. Situational stress is also included in the model in the form of the relationship between the parents (intermarriage, marital disputes), structural stress (excess children, unemployment, social isolation, threats to parental values and self-esteem), and child-produced stress (unwanted child or "problem" child, e.g., one that is colicky, incontinent, a discipline problem, ill, physically deformed, or retarded). Immediate precipitating situations, such as an argument or a misbehaving child, also play a part in bringing on the incident of abuse which may either be a single physical assault, repeated assaults, or even what he calls "psychological violence" such as verbal attacks on the child. This model, then, includes both a social and psychological context and places abuse in a multidimensional perspective.

In the programs visited, virtually all staff discuss the convergence of psychological, sociological, and precipitating situational factors. As will be seen in chapter IX on treatment, all programs seek to provide a therapeutic relationship in order to address and correct psychological problems and a variety of services in order to address and correct sociological and situational factors. No program seeks to meet only psychological treatment needs or to meet only health, employment, housing, nutrition, transportation, education, income, or social/recreational service needs. Every program strives to achieve a balance of psychological and concrete services.

The notion that potential for abuse exists if the parent exhibits the dynamics of abuse and if the family is living under some kind of intense stress is discussed in virtually all programs. This formulation is at the core of the decision that a child has or has not been abused, when as is so often the case the medical evidence is not conclusive. The one remaining link in this complex chain is the child himself; this issue is discussed in the next chapter.

NOTES

1. Costin 1972; Helfer and Pollack 1967; Pollack and Steele 1972; Zalba 1971.
2. Barbero and Shaheen 1967; Caffey et al. 1972; Cameron 1972.
3. Cameron 1972; DeFrancis 1963; Glaser 1968; Johnson and Morse 1968; Lauer et al. 1974; Paulson et al. 1974; Smith, Hanson and Noble 1973; Solomon 1973; Steele and Pollack 1974.
4. U. S. Department of Commerce 1975.
5. U. S. Department of Commerce 1975.
6. DeFrancis 1963; Delsordo 1963; Ebbin et al. 1969; Elmer 1967*c*; Elmer et al. 1971; Glaser et al. 1968; Glazier 1971; Johnson and Morse 1968; Nurse 1964; Silver, Dublin and Lourie 1971; Simons et al. 1966; Tormes; Young 1964.
7. Barbero and Shaheen 1967; Cherry and Kuby 1971; Corbett 1964; Fontana 1971, 1973*c*; Galdston 1975; Holder 1972; Kaufman et al. 1959; Polansky, Hally and Polansky 1974.
8. Bennie and Sclare 1969; Blumberg 1964/65; Bryant et al. 1963; Cherry and Kuby 1971; Fontana 1971; Gil 1970; Holter and Friedman 1968*a*.
9. Fontana 1971; Friedman and Morse 1974; Georgia League for Nursing; Glaser et al. 1968; Johnson and Morse 1968; Morse, Sahler and Friedman 1970; Polansky et al. 1972*a*.
10. Cherry and Kuby 1971; Corbett 1964; Costin 1972; DeFrancis 1963; Georgia League for Nursing; Joint Commission on Mental Health of Children 1973; Nurse 1964; Scott 1973*b*; Young 1964.
11. Elmer 1971; Galdston 1965; Helfer and Pollack 1967; Pollack and Steele 1972; Scott 1973*a*; Spinetta and Rigler 1972; Young 1964.
12. Criswell 1973; Galdston 1975; Helfer and Pollack 1967; Paulson and Blake 1969; Pollack and Steele 1972; C. Smith 1973; Sheridan 1959; Terr 1970; Tracy and Clark 1974.
13. Elmer et al. 1971; Friedman and Morse 1974; Tracy and Clark 1974.
14. Caffey et al. 1972; Morris and Gould 1963; Roth 1975; Skinner and Castle 1969; Wasserman 1967.
15. Bishop 1971; DeCourcy 1973; Isaacs 1972.
16. Costin 1972; DeCourcy 1973; Evans, Reinhart and Succop 1972; Galdston 1975; Green 1974; Johnson and Morse 1968; Leivesley 1972; Roth 1975; Terr 1970; Wasserman 1967.
17. Bishop 1971; Corbett 1964; Costin 1972; Criswell 1973; Galdston 1975; Green 1968; Holter and Friedman 1968*b*; Isaacs 1972; Kempe and Helfer 1972; Morris and Gould 1963; Silver et al. 1969*b*; C. Smith 1973; R. Smith 1973; Steele and Pollack 1974; Zalba 1967.
18. Babow and Babow 1974; Blumberg 1964/65; Brown and Daniels 1968; Caffey et al. 1972; Corbett 1964; D'Agostino 1972; Evans, Reinhart and Succop 1972; Kempe et al. 1962; Paulson et al. 1974; R. Smith 1973.
19. Alexander 1972; Barbero and Shaheen 1967; Bennie and Sclare 1969; Boston Children's Hospital 1974; Cherry and Kuby 1971; Costin 1972; Elmer 1971; Elmer et al. 1971; Flynn 1970; Galdston 1975; Giovannoni and Billingsley 1970; Green 1968; Green et al. 1974; Holter and Friedman 1968*a* and

1968*b*; Joint Commission on Mental Health of Children 1973; Roth 1975; Zalba 1967 and 1971.

20. Barbero and Shaheen 1967; Green et al. 1974; Zalba 1967.
21. Boardman 1963; Caffey et al. 1972; Elmer 1971; Galdston 1971*a*; Green et al. 1974; Holter and Friedman 1968*b*; R. Smith 1973; Steele and Pollack 1974; Zalba 1967.
22. Galdston 1971*a*; Goldberg 1975; Green et al. 1974; Philbrick 1960; Pollack and Steele 1972; Roth 1975.
23. Pollack and Steele 1972; Steele and Pollack 1974; Wasserman 1967.
24. Cameron 1972; Costin 1972; Elmer 1971; Hiller 1969; Holter and Friedman 1968*a*; Kempe and Helfer 1972; Roth 1975; R. Smith 1973; Steele and Pollack 1974; Zalba 1971.
25. Bennie and Sclare 1969; Cosgrove 1972; Elmer 1967*c*; Elmer et al. 1971; Galdston 1975; Green et al. 1974; Helfer and Pollack 1967; Johnson and Morse 1968.
26. Elmer 1967*c*; Elmer et al. 1971; Evans, Reinhart and Succop 1972; Holter and Friedman 1968*b*; Polansky, Hally and Polansky 1974.
27. Cherry and Kuby 1971; Giovannoni and Billingsley 1970.
28. Costin 1972; Elmer 1971; Elmer et al. 1971; Pollack and Steele 1972; R. Smith 1973.

Chapter VIII – Characteristics of the Abused/Neglected Child

INTRODUCTION

This chapter summarizes the literature and field experience with respect to the children of abuse and neglect.

Covered in this summary are:

- Demographic characteristics, i.e., age, sex, birth order, multiple v. singular abuse
- Child-specific precursors to abuse
- Disabilities and deficiencies resulting from abuse

DEMOGRAPHIC CHARACTERISTICS

Age of the Child

Although many abuse laws apply to children as old as 18 and no one denies that children of all ages are abused, most literature focuses on those children believed to be most often or most seriously abused: children under 3 or 4 years of age.[1] Children of this age are more vulnerable to serious physical damage and less able to defend themselves than are older children. In addition, infants are not able to communicate meaningfully with their parents who, often unskilled in child care and themselves replete with unmet needs, become frustrated. The mere presence of a small infant can lead to stress if the birth was neither planned nor wanted.

Many of the studies which conclude that very young children are more likely to be abused are hospital-based studies of emergency room and pediatric inpatient populations.[2] By definition, children included in these studies are the more severely abused children, i.e., those who need medical attention. Gil (1970) opines that these studies overrepresent the younger children. In his nationwide study of every incident reported through legal channels in 1967/68, he found that over three-quarters of the children were over age 2, and that almost one-half were older than 6 years. His two samples, 5,993 children in 1967 and 6,617 children in 1968, also revealed nearly one-fifth to be teenagers. However, in his 1967 analysis, Gil (1970) did find that the younger children were the more seriously injured. Several other studies of reported incidents known to social service agencies[3] found between one-quarter and one-half of their sample children to be over 6 years of age.

As discussed in part I, among the programs visited, the two hospital-based programs report a large majority of children to be under 3 years of age; the social service-based programs in one case report 22 percent of abused children to be over 7 years of age; in another case 61.1 percent of the abused and neglected children were 6 and over, and children 10-18 years old represented the largest single group or 33.5 percent. The other programs visited either do not maintain these data or the data were unavailable.

It seems clear that the age of abused, and particularly of neglected, children is a function of the reporting source with hospitals reporting more of the really young children. Age of reported children is also related to definitional problems. As discussed in chapter V, what is classified as abuse in very young children is much more likely to pass as discipline when related to older children. Moreover, it is possible that suspicion levels in terms of age create the epidemiology in that a reporter who is in doubt and who has been told that abuse is more common in young children may be more likely to decide in favor of reporting a very young suspected abuse case and to decide against the reporting of an older child.

Sex of the Child

In most studies, sex differences seem to be not statistically significant. Although there may appear to be a greater number of abused children of one particular sex, the samples are so small as to preclude any general statements

to this effect. Two studies (Ebbin et al. 1969; Elmer 1967*c*), with samples of 50 and 33, respectively, compared an abuse sample with a normal clinic population and found no significant difference in relative proportions of male and female children. In Gil's (1970) large sample there were sex differences which he related to the age of the sample. In the total study cohort, boys outnumbered girls only slightly (53 percent in 1967, 51 percent in 1968); among teenagers only, girls predominated (63 percent in 1967, 64 percent in 1968). Gil's explanation was that girls, when young, conform to parental expectations to a greater degree than boys do. As they mature sexually, parental anxiety increases as does use of physical force in controlling their behavior.

Two of the programs visited maintain data on large numbers of children. The Hennepin County child protective services program has aggregated data relating to 630 children over a 10-year period from 1963 to 1973; 56.8 percent of these children are male and 43.2 percent are female. Reporting on 373 abused and neglected children during a 6-month period of 1974, the Montana Department of Social and Rehabilitation Services shows that 49.3 percent of the children were male and 50.7 percent were female. However, their breakdown by age and sex shows that the proportion of males and females varies according to age. There is a higher proportion of males than females in the 0-2, 6-7, and 8-10-year-old age groups and a higher proportion of females than of males in the 3-5 and 10-18-year-old groups, paralleling Gil's (1970) findings.

While there may be some slight tendency for boys to be abused more than girls at younger ages because of their greater degree of activity and because of the greater incidence of hyperactivity in boys, these tendencies seem slight. Similarly, the tendency to report more girls than boys in the older age groups may be a function of greater anxiety and tendency to punish adolescent girls on the part of the parents, as suggested by Gil, or it may be a function of more vigilant reporting by community resources which may be more likely to define girls as fragile and in greater need of protection. In other words, physical punishment of boys may be more acceptable than physical punishment of girls.

Birth Order

There seems to be no agreement as to the relationship between birth order and abuse. In two studies the majority of children were oldest or second-born children (Elmer et al. 1971; Glazier 1971). Sample sizes in these studies, in the order cited, are 34 abused and neglected children and 50 children with failure-to-thrive. Youngest children are more frequently abused in three studies (Bennie and Sclare 1969; Cameron, Johnson, and Camps 1966; Jackson 1972) based on sample sizes of 10, 29, and 18 abused children, respectively. Other authors who mention birth order simply state that the abused child is generally one child in the family selected as a target for abuse.[4] Cameron (1972) states that the target is most likely to be either the oldest or the youngest, representing an unwelcome and unwanted beginning or addition to the family. In her study of 33 children admitted to a hospital with abuse related injuries, Elmer (1967*c*) found that there was no statistically significant relationship between birth order and abuse, but rather, that a particular child might be targeted for abuse because his position in the family had special significance for the abusive parent.

Multiple v. Singular Abuse: Repeated Abuse of One Child Abuse of Siblings

Many abused children are not just victims of a single, isolated incident. In the studies reviewed, the proportion of children with a history of repeated abuse varies from 21 percent to 50 percent.[5] Duration of exposure to abuse is included in Nurse's (1964) discussion of 20 probation cases. In these families, abuse occurred over a period ranging from 6 months to over 5 years. The Georgia League for Nursing estimates the average duration of abuse to be from 1 to 3 years. These studies suggest that abuse is not an isolated, one-time event and that therefore, without some form of intervention, abuse will be repeated. Neglect is more likely to be ongoing and chronic and is far more likely to involve all of the children in a family.

Several studies provide evidence that abuse is not limited to one child in the family. Skinner and Castle (1969) found that in the 41 families with more than one child, 49 percent battered more than one of their children. These figures are based on case records of the British NSPCC of abused children under 4 years of age who were in need of medical attention. Simons et al.

(1966) reported a history of sibling abuse in 16 percent of the 313 cases reported to the New York City Bureau of Child Welfare. Glazier (1971), studying 251 reported abuse cases in the Buffalo area, found that 12.5 percent of the incidents concerned more than one child in a family. While these percentages are lower than the 49 percent reported by Skinner and Castle, it should be noted that there may have been unreported cases in which siblings were abused. In the absence of a specific study of each child in the family it cannot be assumed that only the reported child has been abused.

In all probability single v. multiple abuse depends on whether the abuse is primarily motivated by the dynamic relationship between a particular child and his parent(s) or by general stress factors within the family, on whether only one child has been removed so that another child becomes the target of abuse, and on the age of all of the children in the family.

In part I, cases are reported in which all of the children in a particular family have been abused and cases are reported in which only a single child has been abused. In those cases in which only a single child has been abused, it generally seems that the child has particular significance to the parent because the child represents the bad and unacceptable parts of the parent; because the child resembles a hated relative, boyfriend, or exhusband; or because the child is in someway different or special, e.g., hyperactive, colicky, irritable. In some reported cases the abuse, or even murder, of one or more children is seen by program staff as a displacement of the feelings of revulsion toward a particular child who is actually the least abused. Our impression, based on a review of cases presented by the programs visited, is that in at least half of the cases it is not one, but all, or at least several, children in a family who are abused. While only one child may be reported by a hospital or by another source, further investigation shows that several of the children have been abused. In general, when programs receive an abuse report on one child, all of the children should be checked for evidence of bruises and old fractures.

CHILD-SPECIFIC PRECURSORS TO ABUSE

In virtually all studies, some abused children had significant medical histories and disabilities prior to the abusive incident. Nearly one-half of the 20 abused children on which followup study was conducted by Elmer and Gregg (1967) had a history of medical problems. Several had low birth weights, were premature, were ill during the neonatal period, had convulsions or brain damage, or were seemingly predisposed to failure-to-thrive.

Low birth weight and prematurity are discussed by other authors as well. In Silver, Dublin, and Lourie's (1971) sample of 34 hospitalized abused children, the proportion of premature infants was over two times the national average. However, since prematurity is higher among low income groups, comparisons with the national average tend to be misleading. Skinner and Castle (1969) report that 13 percent of the children referred to the NSPCC in 1 year were premature; in all cases early mother-child separation occurred.

Prematurity and low birth weight contribute to the vulnerability of the child. Hospitalization after birth is prolonged, amounting to an enforced separation between the mother and child; a normal relationship or bonding may be difficult to establish. Klein and Stern (1971) studied 51 battered children hospitalized in Canada over a 9-year period. Twenty-four percent had low birth weight as contrasted with an expected United States and Canadian national rate of only 7 or 8 percent. The mean neonatal hospital stay for those infants was 41 days.

Elmer's (1971) accident study also included some abused children who were born prematurely. Approximately one-third of the 34 abused children weighed less than 5.5 pounds at birth. None of the nonabused children weighed below that level. Elmer explains that premature infants cry more, are more irritable, and thus place a greater strain on families with few resources.

In addition to prematurity or illness during the neonatal period, a number of authors have studied physical or developmental deviations which antedate abuse. Johnson and Morse's (1968) sample of 101 children included 70 percent who had physical or developmental deviations before the injury was reported (Costin 1972). However, in most cases it is difficult, if not impossible, to differentiate between those factors specific to a child which may predispose him to abuse and those factors which may as easily be the consequences of abuse. This chicken and egg problem makes

it impossible in most cases to determine to what degree a particular child, by virtue of his special physical, developmental, or intellectual handicaps, was predisposed to abuse.

Gil (1970) found that 29 percent of his sample cohort were deviant in social and intellectual functioning during the year preceding the reported incident. Fourteen percent were physically deficient. Nearly 13 percent were below their age appropriate grade level. Prior to the reported incident, 17 percent had been hospitalized for physical illness, 9 percent were in foster care, 4 percent were known to juvenile courts, and nearly 4 percent had been in child care institutions. Gil states that this level is "... in excess of the level of any group of children selected at random from the population at large ..." (p. 108). However, Simons et al. (1966) report that the proportion (10 percent) of their sample (313 children reported abused in New York City) that had severe prior defects, e.g., brain damage, eye and orthopedic impairments, was not that different from the percentage of such disorders in the total New York City child population.

The literature on behavioral characteristics is of a descriptive rather than analytic nature. The problems of deciding whether these behavioral characteristics are the cause or the result of abuse is monumental.

Johnson and Morse (1968) differentiate between the behavior of children younger than, and older than, 5 years of age. Younger abused children are described as whiny, fussy, listless, chronically crying, restless, demanding, stubborn, resistive, negativistic, unresponsive, pallid, sickly, emaciated, fearful, panicky, and unsmiling. Older abused children are described as gloomy, unhappy, depressed, insincere, inconsiderate, deceitful, openly expressive of disrespect toward their fathers, and ingratiating toward their mothers. However, these two sets of characteristics do not appear to be that different from each other. The authors state that the children most likely to be abused are the ones who are overly active and most difficult to manage. Because of their failure to respond to care and to grow in a normal manner, they are seen as threatening or at least not gratifying to the parents' self-image.

Terr (1970) delineates three types of relationships of the abused child to his family. First, the presence of a physical abnormality such as failure-to-thrive may be an irritant and guilt producer to the mother. The fact that the child does not devleop properly is a reflection on the mother's child care skills. The second type of relationship concerns ego defects which are secondary to maternal deprivation. Thus, there exists a shallow relationship between parent and child. The child withdraws and becomes indifferent to the mother. The third relationship consists of retaliatory activities on the part of the child. Hostile behavior by the child worsens an already strained interaction.

Program staff was asked to consider all of the abused children they had known and to make an estimate of the proportion of these children who presented a problem which an independent observer agreed could make that child especially difficult, e.g., physical handicap, colicky baby, hyperactivity. Estimates within and across programs ranged considerably from 10 percent to 40 percent, but the majority of estimates were approximately 20 percent. Thus, about one-fifth of the children, according to program staff, could be considered as predisposed to abuse; the majority of children are described as attractive and appealing youngsters or infants.

DISABILITIES AND DEFICIENCIES RESULTING FROM ABUSE

As a result of abuse, children suffer, in varying degrees, from both physical and mental defects. When abuse is first diagnosed, prevalent physical characteristics include large heads, protruding bones, bruises, poor skin hygiene, multiple soft tissue injuries, malnutrition, and smallness for the child's age.[6]

Holter and Friedman (1968*a*) describe the nature of abuse injuries and compare them with neglect and accident injuries. The authors completed two surveys: in the first, 69 accident cases involving children under 6 years of age seen in a hospital emergency room were reviewed in terms of type of injury, explanation, and signs of abuse or neglect. In the second survey, 87 cases were similarly reviewed and home visits were made by a public health nurse. Eleven percent of the two survey samples were suspected to be incidents of abuse. Injuries displayed by suspected abused children (who were all considered high risk) consisted of head injuries, fractures, dislocations, limb injuries, burns, abrasions, contusions, and bruises. The

accident (nonabuse) group exhibited lacerations and ingestions. An additional important difference between the groups can be seen in the delay between time of injury and emergency room visit. The timespan amounted to 4½ hours for neglect cases, 2 hours for abuse, 1 hour for accident, and three-quarters of an hour for repeated accident cases.

A followup study of these same children 5 years later (Friedman and Morse 1974) found that over 70 percent of the suspected abuse and neglect groups had injuries requiring medical attention in that interval. Only 50 percent of the accident group needed additional medical care.

Neurological damage is a common after-effect of abuse. Morse, Sahler, and Friedman (1970) report that 71 percent of the 25 children (all surviving children treated for abuse from 1963 to 1966) they studied 3 years after hospitalization for abuse or neglect were outside of the normal range of intellectual, emotional, social, and motor development. Forty-three percent were mentally retarded. Martin (1972) also reports that same proportion having permanent brain damage in his sample of 42 abused children followed by a child development center. Thirty-three percent of his sample was also diagnosed with failure-to-thrive. He found that syndrome occurred twice as frequently in children who were functionally retarded as in children who could subsequently function normally.

Elmer's (Elmer and Gregg 1967) studies also show a high proportion of retardation. Fifty percent of the 20 abused children restudied after a span of from 1½ to 10 years after hospitalization for multiple bone injuries were retarded; one-third had physical defects; and eight were emotionally disturbed. Her comparison of another group of 34 abused children with 67 accident victims produced the following results: The abused children had twice the incidence of neurological problems as the children with accidental injuries.

Johnson and Morse (1968) discuss the disabilities of 101 abused children known to the Denver Welfare department. The following problems were present: "uncontrollable" severe temper tantrums (19 percent), below normal speech development (18 percent), mental retardation (16 percent), toilet training problems (15 percent), feeding problems (13 percent), physical handicaps (7 percent), and brain damage (1 percent). Twenty-five percent of the 52 children under 5 years of age were below normal in language development; one-half suffered from malnutrition, dehydration, and failure-to-thrive.

Galdston (1971*a*) lists two types of behavior displayed by physically abused children. They may be listless, apathetic, and unresponsive to all but painful stimuli or they may be extremely fearful, recoiling from contact with anyone. While abused children may, in fact, recover from the harmful experience, Galdston states that once a child reaches the age of 3½ or 4 there is great difficulty in correcting the damage.

Lukianowicz (1971) characterizes the long- and short-term effects of battering. Short-term effects refer to changes in appearance and behavior (listlessness, withdrawal, apathy), changes in attitude toward parent (fear), and psychosomatic symptoms of emotional stress (refusal to eat, vomiting, bedwetting). Longer-term effects which can occur include, again, withdrawal, timidity and fear, rebelliousness, and becoming an abusing parent. Brain damage is also a possibility.

A number of other authors also describe the emotional and relationship problems of abused children. Costin (1972) states that abused children are shy and have low self-esteem; Zalba (1967) reports that they tend to be depressive, hyperactive, destructive, fearful, withdrawn, as well as bedwetters, truants, fire-setters, and overreactive to hostility. They are described as having a lack of trust in the parent and difficulty in mastering the stages of autonomy and initiative (Martin 1972). Bryant et al. (1963) states that the abused child has a seriously impaired relationship with the abusive parent. The child may also accept the parents' bad image of her/himself, as a form of loyalty (Kempe 1969). Acute anxiety is exhibited through such symptoms as speech problems, sleep difficulties, thumbsucking, and nail biting (Lewis et al. 1969). Leontine Young (1964) describes the children she studied as detached from feelings and from other people and lacking in energy and purpose. They take on the role of scapegoat of the family and feel unloved; their needs go disregarded (Steele and Pollack 1974). Curtis (1963) reports an unusual degree of hostility toward the parents and toward the world in general. Some of the above characteristics could lead to the child's inviting others to hurt him (Milowe and Lourie 1964).

Typical hospital behavior of abused children is described by Morris, Gould, and Matthews (1964). When brought in for treatment, these children: (1) cry hopelessly, (2) do not look to parent for assurance, (3) do not expect to be comforted, (4) are wary of physical contact, (5) are apprehensive when other children cry, (6) are apprehensive when adults approach other crying children, (7) are alert for danger, (8) continually ask what will happen next, (9) are in search of such things as food, favors, things, services, (10) show a "poker face" when discharge home is mentioned, and (11) do not suggest that they want to go home.

Violent behavior has been frequently mentioned as characteristic of abused children. Galdston (1975) describes its presence in children attending the Parents' Center Project, a therapeutic day care program. The author states that these children use violence as a major way of seeking attention. After several weeks in the program the children were able to express emotions in other, more acceptable, forms; however, none lost their violent behavior completely. Another specific behavior manifested by these children is the "grabbing reaction." The children, wanting a belonging relationship, will grab an object from someone else. Once taken, however, the object ceases to be an attraction.

Neglected children are discussed by several authors; however, their descriptions are no different from those dealing with physically abused children: withdrawn, hostile, depressed, antisocial, and passive.[7] There is difficulty in establishing a one-to-one attachment, a bonding, between child and mother. The same traits are used to describe children diagnosed as failure-to-thrive.[8]

Gardner (1975), in summarizing the work of the Gilday Center in Boston, a day care center for abused children, described the children as follows:

> We cannot offer any typical behavior or personality pattern which would fit every abused child, although we have certainly learned what kinds of behavior to expect. For example: these children are much more apt to comfort an upset adult than to expect comfort when they are upset. They may be wary of physical contact of any kind. Their capacity for being 'given to' is boundless. They show little or no distress at separation from parents. They can be very manipulative of adults from a very early age, and they are often accomplished actors. They sometimes respond negatively to praise as if it were safer to be 'bad.' They are generally reluctant to engage in any messy activities. Some seem highly skilled at provoking adults to anger, while others indiscriminately seek affection from any adult. Their language development is generally slow, and many have speech impediments. They demand immediate gratification and find it almost impossible to wait or take turns. Some are extremely well coordinated and others have little sense of body awareness. Initially, they seem completely without the normal childlike sense of joy (pp. 149-150).

The Bowen Center, one of the programs described in part I, has had 9 years' experience in the treatment of abused and severely neglected children. Their description is as follows:

> The limited backgrounds of our children, their suspicion, their unfamiliarity with success, make them view each new experience as a potential threat, and we must literally decoy them into participation in any new activity. The sense of fun one normally sees in preschoolers is totally lacking.
>
> One is struck by the differences our children display as compared to less deprived youngsters. The expression on their faces is old and worried, they rarely smile. They relate to staff either by clinging to anyone available, or they attack. They are all frightened and share a general distrust of a new situation. Their behavior is provocative, literally inviting violent response.
>
> Their initial approach to materials is indiscriminate hoarding, trying to accumulate as many things as possible, but with no drive to use them, only to collect. They are unable to use free play periods constructively.
>
> Although we observe little overt difficulty with separation, the children appear to be undifferentiated from their mothers, i.e., if mother is sick, they experience themselves as being sick, if a parent is away from home they tell us 'Daddy dead' in a flat tone.

Children manifesting the failure-to-thrive syndrome exhibit different characteristics than do physically abused children, although both types of abuse may be present in one child. Gregg (1968) makes a distinction between the failure-to-thrive syndrome and physical abuse. Whereas physical abuse may represent a one-time occurrence, failure-to-thrive is generally of longer duration. Children with complaints suggesting systemic disease not related to trauma instead suffer from longstanding neglect which may be accented by abuse. Barbero and Shaheen (1967) divide the syndrome into four clinical forms. Failure-to-thrive may occur: (1) without systemic disease but with family disruption, (2) with clinical manifestations, e.g., vomiting, diarrhea, anemia, respiratory problems, neuromuscular disorders, (3) accompanied by trauma (physical abuse) and (4) as an accompaniment to primary systemic disease which precipitates family disruption and contributes indirectly to the syndrome.

Bullard et al. (1967) studied hospital records of 151 children exhibiting the failure-to-thrive syndrome. Fifty of the children studied had no primary organic illness. In most cases, the syndrome began in early infancy, progressing until the child was 6-12 months old when hospitalization occurred. As in physical abuse cases, other disorders were present. More than one-half of the 41 children followed up from 8 months to 9 years after hospitalization showed continued growth failure, emotional disorders, mental retardation, or a combination of those problems.

Glaser et al. (1968) report that of the 50 children with failure-to-thrive in their study, 37 percent (N = 19) had failed or had difficulties completing the first year of school. Over 40 percent (N = 40) continued to show physical evidence of their earlier state between 6 months and 8 years after discharge. Of course, school failure and later physical problems cannot be attributed to failure-to-thrive alone as both of these can be consequences of poor parenting.

Exploited children, as described by Galdston (1971*a*), are children who do not act their age, whose attitudes, interests, and behavior are not appropriate to their age. The child functions to gratify the parent and fulfill the parents' image. Galdston gives several situations of exploitation. An obese child may be fulfilling the parent's desire to eat; a child with disordered behavior who is often involved in accidents may be gratifying the parent's desire for violence. Sexual abuse is another category of exploitation. The parent is fulfilling his needs through the child. Sexual abuse is also dealt with by Tormes, and Schultz (1973). Tormes characterizes the sexual abuse victims by their lack of socializing and exposure outside of the family. Schultz describes the deep relationship established between the abuser and the abused as one where the victim seeks out affectionate behavior from the parent.

There are two additional studies in the literature which offer insight into the behavioral effects of abuse. Babow and Babow (1974) have published a verbatim case study of a 21-year-old female with a long history of abuse by her mother. She had repeatedly tried to commit suicide and was diagnosed as schizophrenic. Her explanation for the suicide attempts and other self-destructive behavior was that they were a punishment for what she saw as the bad thing she had done: being born when not wanted. The second study (Green 1968) involved school-age schizophrenics with a history of abuse who were enrolled in a residential treatment center. The parent-child relationship in these cases alternated physical abuse with periods of withdrawal and threats of abandonment. The abused children attempted to inflict pain on themselves in order to recreate whatever parental contact existed.

The behavioral characteristics of children as reported in the literature are certainly supported by program experience. Multiple foster home placements are often precipitated by the behavioral problems manifested by the children whose behavior can be so difficult to tolerate that they lead to one rejection after another. Many of the children feel that the abuse is a punishment for their fundamental badness and they experience out of home placement as proof of their badness. Thus, in the new setting they continue to act out their negative self-image and to precipitate the punishment they know must be forthcoming. In addition, many of these children, having never experienced a firm and consistent limit-setting approach, are in fact very difficult to live with in a home which is not given to chaos.

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The contrast between the vast amount of literature reviewed in the previous chapter and the relative paucity discussed in this chapter is no accident. It points up the fact that most authors, most researchers, and in fact most programs are addressed primarily to the needs of the parents. Much of the interest in parents is based on a desire to deal with root causes so that precipitating social problems can be eradicated and so that treatment can be focused. But beyond this interest in parents in the name of prevention and treatment is an interest in adults which supercedes interest in children. In general, in the field of abuse and neglect, children are second-class citizens.

Of all the programs visited, only one is seriously addressed to the needs of abused and neglected children. By and large, as will be discussed in the next chapter, treatment programs are designed to meet the long-range needs of parents rather than of children. Children suffer incredible pain and hurt, children are placed in long-term foster care storage with little opportunity to understand or to work

through what has happened to them, and children continue to live in homes which are harsh and rejecting. In all too many cases, children are seen by a worker only in passing as she/he visits with the parents and in many cases are asked to leave so that parent(s) and worker can talk. No one works with the children or helps them to cope with the same life conditions which are felt to be too difficult for adults. The majority of social workers and protective services workers have no training in how to work with children or adolescents; many of them state openly that they are not comfortable dealing with children and adolescents.

Our review of the literature suggests that not only are children's needs underaddressed but that in addition there has been little attention devoted to a study of the interaction, under a variety of circumstances, between abused children and their parents. Efforts at developing typologies which can be useful for prevention and treatment are primarily centered on the dynamics of the parents rather than on the kinds of interaction which may be causing abuse. This lack of attention to parent-child interaction is also reflected in the kinds of treatment modalities that have been developed in abuse programs. As will be seen in the next chapter, family therapy which focuses on interactional variables is in a barely nascent state in this field.

NOTES

1. Corbett 1964; Costin 1972; Fontana 1971 and 1973*c*; Galdston 1965 and 1971*a*; Gelles 1973; Georgia League for Nursing; Skinner and Castle 1969; Solomon 1973.
2. Cameron, Johnson and Camps 1966; Ebbin et al. 1969; Elmer 1967*c*; Elmer et al. 1971; Evans, Reinhart and Succop 1972; Friedman and Morse 1974; Heins 1969; Holter and Friedman 1968*a*; Jackson 1972; Lauer 1974; Paulson and Blake 1969; Zuckerman 1972.
3. Bryant et al. 1963; Glazier 1971; Johnson and Morse 1968.
4. Boardman 1962; Brown and Daniels 1968; Caffey et al. 1972; Costin 1972; Joint Commission on Mental Health of Children 1973.
5. Bennie and Sclare 1969; Gil 1970; Joint Commission on Mental Health of Children 1973; Lauer et al. 1974; Morse, Sahler and Friedman 1970; Paulson et al. 1974; Simons et al. 1966; Skinner and Castle 1969.
6. Kempe et al. 1962; Leivesley 1972.
7. Galdston 1971*a*; Polansky et al. 1972; Polansky, Hally and Polansky 1974.
8. Bullard et al. 1967; Elmer et al. 1971; Evans, Reinhart and Succop 1972.

Chapter IX — Identification, Case Management, and Treatment

This chapter summarizes the "state of the art" with respect to identification, case management, and treatment. The reader who is primarily interested in these issues is also referred to the program case studies in part I as the treatment approaches, processes, and techniques of each program, as well as case examples, are presented in that section.

The literature relating to identification, case management, and treatment encompasses discussions of management by various agencies, types of treatment, roles of professionals, constraints to treatment, and descriptions of existing programs. Most of what is written is general in nature. There exist few objective criteria which can be used as a basis for determining which treatment modality is best for whom; there are virtually no criteria for the measurement of success in treatment. Similarly, there are few case presentations which illustrate the process and techniques used in various treatment approaches.

IDENTIFICATION

Most professionals whose experience is with severely abused children who first come to the attention of a hospital-based program believe that, as a first step, the child should be hospitalized.[1] Hospitalization permits use of diagnostic procedures, including skeletal x-rays, time for the parents to be away from the child, a protected environment for the child, and time to connect the family with an array of services. Most authors feel that if such hospitalization is refused by the parents, it should be provided under court order. The need for, and use of, a team approach within the hospital has already been described in chapter VI. For a detailed description of the functioning of such a team within a hospital, the reader is referred to the Pittsburgh Children's Hospital case study presented in part I. Essentially, the hospital team has responsibility for educating hospital staff, for reviewing charts on new admissions, for providing consultative services to professionals in the hospital, for interviewing the parents, for reporting abuse cases, and for creating a climate which favors identification and reporting.

Newberger and Hyde (1974), together with many professionals in the field, recommend that no attempt be made to establish guilt or to create a climate of blame because such an approach tends to impede the establishment of trust in the professional. Of more importance than determining whether or not the injury was intentional is a focus on what measures can be taken to improve the child's environment and help the parents. While blame is to be avoided, most professionals agree that honesty and a forthright approach to parents is crucial. Professionals have the responsibility of sharing their suspicions with parents, of letting them know that a report will be made, and of informing them as to what will happen next. The primary message is "we cannot allow this to happen, we believe that you also do not want it to happen and we are here to help you."

While hospitals, if they have a team and a set of procedures, are often in the frontline of case reporting, the primary responsibility for case identification and investigation rests with the public social service agency or a specially created abuse program with which the public agency contracts. Within social service agencies and their contracted programs, case investigation is best carried out by a specified person or unit with the sole function of validating reports from other agencies and from the community at large. Some agencies validate abuse cases on the telephone and refer confirmed cases directly to an abuse worker. Other agencies carry out a face-to-face investigation through interviews with the family and with other agency staff to which the family is known and only then refer the case to an abuse worker, if warranted. While direct referral to a field worker results in some waste in field workers'

time when cases are not validated, most professionals feel that the initial contact with abusive parents is so important that it is best made by the worker who will continue with the case. Virtually everyone in the field recommends 24-hour coverage and availability of a worker who can make an investigation and take necessary action in the middle of an emergency. Most protective services programs stress the importance of providing the reporters with some feedback following the initial investigation. Such feedback serves to let the reporter know that the agency is following up on the report and will take necessary actions. Great caution should be taken, however, to avoid providing feedback which violates the privacy of families under investigation.

As discussed in chapter VI, case investigation and decisions about who should be required to accept services are often extremely difficult because of definitional problems. Cases in which there is clear medical evidence of abuse will hold up in court, so that if parents refuse services, they can be court ordered and/or the children can be removed from the home. In some cases, recognition that legal action exists as an alternative to social casework contributes to the parents' willingness to accept services. However, in encouraging the acceptance of service, the caseworker must, at the same time, be minimally demanding.

In the majority of cases known to protective services and to abuse and neglect programs, hard medical evidence is absent. In these cases, program staff have to use all of their skills, patience and persistence in convincing parents to accept services and a therapeutic relationship. Honesty, a clear concise statement of the law, active outreach, compassion for the plight of the parents, and an action message designed to convey a stance of friend and ally rather than of accuser and foe appear to be the essential ingredients. The role of the protective services worker is particularly difficult because she/he must convey both a sense of compassion and a sense of the authority invested in this role. Some parents react with relief, others react with rage and indignation. Successful professionals in the field are characterized by a high tolerance for anger, a relative absence of fear in the face of rage, a willingness to act as a sponge for anger, and an ability to use their authority while conveying sympathy and understanding.

Parents who refuse to acknowledge their abusiveness can sometimes be engaged if the worker offers to help them learn to be more effective parents or if the worker offers a service to help them deal with what they perceive as a difficult child. In these cases the message is "let us not continue to argue over whether or not it was you who hurt this child, instead let's agree that he was hurt and somehow you missed what was happening" or "I can see he's giving you a hard time, let's see if we can work together to make things easier for you."

Staffs at all of the programs visited highlight the special problems associated with identification of abuse in middle-class parents. Such parents, who may have extensive and well-placed ties within the community, are more likely to be given the benefit of the doubt during the investigation process because to all outward appearances the home situation may look so much better than it does in low-income families or because the very status of the middle-class families affords them a measure of protection. Nevertheless such parents do need help and all programs have been able to work with them effectively.

CASE MANAGEMENT

Case management is defined as the coordination of the multiplicity of services required by the majority of abusive and neglectful families. Such services include day care, foster care, homemaker services, and public health nurse visits. It also includes medical, legal, financial, and employment assistance. It is a broad approach that places increased emphasis on the manipulation of the environment. Thus, this approach focuses more on the life circumstances of the abusive parent than on the personality of the abuser.

Delivery of Concrete Services

Collaboration and cooperation by various agencies are essential in providing treatment and long-term followup. Use of social services represents a movement away from the view of the abuser as a criminal to the view of him/her as a person in need of help.

Silver (1968) differentiates the social service or protective services program from an approach using the police department as primary agency.

The first approach leads to evaluation and assistance by a social service worker. The child may be placed elsewhere but the emphasis is on assistance to the family. In the second approach mentioned by Silver, the police department investigates the incident. While they may be the only service open around the clock, their intervention may result in defensiveness and increased intransigence on the part of the parents.

Homemaker services and home visits by nurses, social workers, and other professionals are frequently mentioned in the literature as a vital social service treatment component.[2] Homemakers can become emergency caretakers when children are left alone; they can also serve as maternal figures establishing a daily routine for the parents and helping alleviate personal and social isolation. Since the abusive family may fear getting involved with agencies, the homemaker can coordinate agency involvement in the home and can observe and evaluate family interaction from a closer viewpoint. Homemakers who have received some training in home management and can assist with budget planning, shopping, and preparation of meals can be particularly helpful.

Homemakers, while frequently mentioned in the literature, were available in only one of the programs we visited. Programs operated by the public social service agencies have a dearth of homemakers and in most cases the few available homemakers are assigned to the elderly and the disabled. Abuse and neglect programs visited outside of the public arena do not have homemakers on their staffs nor do they make referrals for such services.

Day care intervention and crisis nurseries are also a means of case management.[3] The time spent by the child in a day care facility provides an "escape" for the parents. In some programs, the parents are required to attend group meetings. Through such intervention, it is hoped that the parents will be able to get pleasure from the child. The Joint Commission on Mental Health of Children (1973) maintains that day care is immensely important and assumes that if more child care services were available, the incidence of abuse would decrease. Day care can also be seen as an important therapeutic tool in the effort to work through the parents' symbiosis with the child.

Most programs contract for day care services either in day care centers or in licensed day care homes. Two of the programs we visited have developed their own day care services in recognition of the fact that abused children are often not tolerated in day care settings designed for children without severe emotional and developmental problems. In communities which have such specialized day care programs, there tends to be a close working relationship between the day care center and the abuse/neglect program. As discussed in chapter VIII, the importance of quality day care for abused and neglected children cannot be overstated.

The availability of caseworkers on a 24-hour basis and the need to set up some mechanism within the child abuse and neglect program by which staff share this responsibility on a rotating basis and receive compensation in time or dollars are discussed by many in the field. It is not only that abuse in cases not yet known to the program occurs on an other than 9-5 basis, but also families in the program need to feel that someone is available to them at times when they feel that they absolutely cannot cope.

In most of the programs visited, part of the effective outreach effort of the staff includes not only home visits, but availability of the staff to clients during after office hours. In many programs, staff provide clients with home phone numbers and make it clear that they are available and should be called in case of crisis.

Most of the programs visited maintain a very close working relationship with the local public health agency. Public health nurses seem to be an invaluable resource in terms of followup care for abused infants and failure-to-thrive cases post hospital discharge. In many communities, public health nurses have a far better image than do protective services workers and at times they are the first line of approach to a family. Their skills in monitoring the progress and development of young children, in providing a relationship of friendly support and guidance in adequate child and health care, and their knowledge of nutrition, are extremely important assets. In programs which include joint staffings between caseworkers and public health nurses, the contributions of the public health nurses to case management and to service delivery are very clear. Programs which have not developed a close collaborative relationship with the public health agency are failing to take advantage of a major treatment resource.

Family planning services are also considered to be very important and some programs consider these referrals a high priority.

Responsibility for coordinating services and for ensuring that services are actually delivered rests with the social services worker assigned to the family. The skills required for this complex task are a highly developed diagnostic sense in terms of decisions regarding which services are or are not appropriate, a knowledge of the resources available and of their eligibility requirements, and organizing skills which allow the worker to stay in touch with service deliverers in other agencies on a case-specific basis.

An effective case manager is one who knows how to engage the parents in the planning-for-services process, who personally introduces the family to each new service provider in order to promote the new relationship, and who maintains regular contact with all service providers involved with a given family. In communities in which there is more than one resource, e.g., where there are many day care centers, the case manager needs information about each resource and the quality of services to be expected. Thus, the case manager needs access to an updated resource file or has to do his/her own checking on the services available.

Interagency Child Abuse and Neglect Teams

In light of the multiplicity of services required by most abusive and neglectful families and in light of the fact that no single agency is able to provide all of these services, a number of authors call for persons working in the field of child abuse and neglect to act as a team in dealing with the problem.[4] Interagency efforts are emphasized, consisting of representatives from the medical, nursing, law enforcement, social service, and mental health professions. Team management is viewed as the means for preventing the fragmentation of services which is otherwise so common. That is, a single professional, aware only of his own role and providing only one type of service, tends to lose sight of the role of other service providers. Without a team approach, unsuccessful referrals are often not followed up because of lack of coordination and cooperation. With this fragmentation also comes a lack of common standards to be adhered to by workers in the field leading to even less communication.

The two community-based interagency teams visited by CRA and described in part I illustrate clearly that in relatively small communities in which no one agency has a staff which is large enough to form an informed team, the teams serve as a source of education, consultation, and support for the activities of its members and for other staff within the agencies represented on the team. In larger communities, in which each agency may have its own child abuse team, the interagency team serves as a coordinating mechanism. A team approach is relatively effective in terms of ensuring that cases are not overlooked and that services which are promised by a particular agency are, in fact, delivered. In other words, the team may have a beneficial watchdog function on the operations of all of the member agencies.

One of the chief obstacles to the development of a team approach is often the public social service agency which prefers to retain all of the authority as well as the responsibility it is given under law. In other words, social service agencies tend to be reluctant to allow other agencies to become formally involved in the provision of services to protective services cases. Typically, the impetus for the formation of an interagency team does not come from the public social service agency but rather from the medical, public health, mental health, and law enforcement agencies. In some communities, representatives of these agencies have agreed to meet without including the public agency which has then been forced into capitulation, i.e., participation. It generally seems to take a minimum of two years to bring all of the agencies together and to work out the turf problems and interagency mistrust which often characterizes the early startup period of these groups.

In our experience, professional awareness and understanding of child abuse and neglect are greatest in those agencies which have either developed their own team or are participating members of an interagency team. When team members take responsibility for reporting back to the staffs of their agencies and for developing a workshop or seminar, increased reporting and development of services seem to follow.

As professional coordination develops in a community and as procedures and criteria for action are formulated, one of the responsibilities placed on the team is the development of education programs for professionals in the community. Such educational programs are developed for the purpose of acquainting health, social service, law enforcement, child care, and education professionals with all aspects of

abuse and neglect. There is general agreement as to what topics should be included in the program: the dynamics or indicators of abuse and neglect, the feasibility of therapeutic intervention, definitions/criteria for reporting, reporting procedures, immunity, agency/professional roles and responsibilities, and community resources. Such education efforts are important because professionals tend not to receive specific training regarding child abuse and neglect during the course of their professional education. Once such training is included in the curricula of professional schools, it has been suggested that questions on maltreatment and reporting procedures be included on licensing exams (Grumet 1970).

TREATMENT

In practice, it is sometimes difficult to draw the line between case management and treatment. In some public social services agencies where workers are responsible for anywhere from 40-80 cases and have very limited training, the relationship between worker and client may be called a "treatment" relationship but, in our view, this is a misnomer because the worker only makes referrals to other agencies and at best sees the client every few months.

Programs in which there has been little emphasis on the development of different treatment skills and techniques and little contact with professionals representing a variety of treatment approaches tend to rely on a supportive social casework relationship with a single individual, in most cases, the mother. Without specific training and supervision, most caseworkers find it difficult, if not impossible, to engage in family or couple therapy or to use specific intervention techniques, e.g., behavior modification or transactional analysis. In general, except in the specially developed treatment programs, there is only minimal opportunity for case presentations in which the focus is on treatment and for discussion of case-specific treatment alternatives and strategies on a session-to-session basis. Similarly, there are very few opportunities for workers to team up with more experienced therapists or with therapists who have a recognized skill in using a particular treatment modality or technique.

All too often, what passes for inservice training or supervision is little more than a set of administrative meetings or meetings designed to make case disposition-type decisions. Meetings designed to review the status of a worker's entire caseload most often serve as a substitute for case presentations with a focus on treatment issues.

In most of the programs visited, treatment is provided either by social workers with MSWs or by individuals without professional education who are called social workers or caseworkers. The range of skills represented by individuals across programs and even within programs is monumental. Some individuals are able to listen in a friendly and supportive manner and to make occasional suggestions, others have an armamentarium of specific skills and techniques. Some individuals provide what is essentially a friendly visiting service, others have real knowledge of how to work for behavior and internal change. Professional training appears to be less important than the interpersonal skills of the worker and the quality of the supervision and opportunities for learning which are provided in the program in which she/he works. Programs which have developed a group therapy or couple therapy approach in which there is contact with outside clinicians who regularly use a variety of techniques tend to develop a staff which has a broader variety of skills and intervention techniques.

The definition of what constitutes a professional varies from community to community. It is ironic that a protective services worker with a BA is called a professional because she/he earns a salary, while volunteer workers in the SCAN, Arkansas program (described in part I), who, in many cases have far more intensive training and supervision, are called lay therapists. It is difficult to imagine the circumstances under which a "professional" with monthly contact and no real supervision can be more effective than a volunteer with two or three weekly contacts *and* ongoing supervision.

In the programs visited there is a tremendous range in terms of caseload size from five families per full-time worker in one program to approximately 25 families per worker in another. Programs in which workers have a smaller caseload tend to be more active with their cases and see them a minimum of once a week. Because of the great amount of time which has to be spent in service coordination and because of the time which should be spent on staff development and inservice training, it does not seem possible that intensive therapy can be conducted with caseloads larger than 15-20.

One-to-One Treatment: Casework, Psychotherapy, and Lay Therapy

Much of the literature on social casework intervention is of a rather general nature. As Roth (1975) has said, social casework is a widely used mode of treatment designed to motivate the abusive parent(s) to understand their situation as part of a crisis and to receive help from the agency. After determining the facts and making disposition-related decisions, the caseworker's primary role is to act as a guide to and liaison with other services. The caseworker must, according to Polansky, Hally, Polansky (1974), act as an individual "change agent." Within this role, the caseworker becomes an object attachment, a role model, and a behavior modifier, assisting the parent in the management of interpersonal relationships. The caseworker must also mediate between family members by encouraging verbal communication, resolving conflicts, and being supportive of the entire family.

While some authors, as discussed below, point up the need to work with children, in reality this is relatively rare due to the lack of specific training in child therapy or counseling.

Roth (1975) states that in managing abuse cases it is important to focus separately on the parent and on the child, helping the parent meet his own needs, and helping the child work out ambivalent feelings about his parents. Other areas highlighted by Roth include the need to pay attention to the child's fear that something is wrong with him, his fear of future abuse, and his need for affection. Arvanian (1975) discusses the importance of alignment of the social worker with the mother but also the value of the social worker supervising play sessions between the mother and child. Mulford (1958) summarizes this area of focus by stating that treatment must be based on the needs of both parents and children.

Goldberg (1975) advises the social worker in techniques to be used during casework. The first technique concerns the physical positioning of the worker: maintaining frequent eye contact with the parent, using a moderate voice, avoiding rapid speech, etc. These are all attitudes designed to make the client feel as comfortable and as unalienated as possible. Another technique consists of "reaching for feelings," that is, verbalizing nonverbal behavior or verbally describing feelings. Here, the social worker would comment "that can be frightening" to enable the client to continue to react to the social worker's presence without use of direct questioning. Time should be allowed for the parent to compose himself and engage in internal dialogue. Thus, the social worker is cautioned not to jump in with one question after another. "Getting with" is another important concept that indicates to the parent that his feelings are understandable. In order that the session is not construed as interrogation, the social worker is advised to ask for information using open-ended questions. Close-ended questions should only be used to clarify a statement or focus on key points.

In some of the programs visited, it was pointed out that statements which seek to inform the client that his/her feelings are shared by others are helpful, whereas interpretive statements designed to reach feelings tend to backfire in that they may be experienced as confrontation and serve to increase defensiveness. Thus, for instance, the statement "that can be frightening" conveys the message that others in the same situation would also be frightened, whereas the statement "you seem frightened" may produce a defensive "I certainly am not" reaction.

Most therapeutic programs begin with a fundamental understanding of the abusive parent as a person with intense unmet dependency needs. Since the abusive parent is seen as one who has experienced significant rejection, if not actual abuse, who lacks any means for obtaining dependent gratification or emotional support from others because of a basic lack of self-esteem and trust in others, and who uses the child as a need-gratifying object, most treatment is initially addressed to developing a close dependent relationship between parent and worker. Meeting the dependency needs of the parents and providing a firm limit-setting relationship or reparenting is the central operating concept of many treatment programs.

Psychotherapy is emphasized by Steele and Pollack (1974) who state that the treatment goal is to induce the patient to look to the therapist to find out how to fill his own needs. The therapist must offer statements of sympathy without criticism. Of primary importance is change in the parent-child interaction such that the danger of physical and emotional abuse to the child is eliminated. Also important is a change in the parents' "psychic functioning"

so that they are better able to handle intrapsychic conflict, marital, and other interpersonal relationships, particularly with their own parents, and problems of daily living. The abuser should be encouraged to form outside social contacts. Steele and Pollack (1974) and Davoren (1974) also propose as a supplement to therapy, home visits by a social worker as a source of satisfaction and as substitute mother to the abuser. The social worker should also have a firm knowledge of child behavior.

Some programs use volunteers under the supervision of psychiatric and psychological consultants who answer telephone calls from persons seeking help and then make home visits. Although these particular models of treatment are not discussed in terms of specific techniques, statements are made as to the role of the therapists who are initially viewed as part of the "establishment" to which the parents respond angrily. As they become more trusted, they assume the role of parent surrogate. Until the relationship is secure, however, therapists cannot be too demanding of the parent; any coercion is seen by the abuser as authoritarian.

Kempe and Helfer (1972) discuss the use of lay therapists or parent aides who visit the homes of battered children and their parents. Because abusive parents are deficient in knowledge of parenting, parent aides work with the parent in that area as a mature and reliable friend. Parent aides, matched with parents by social and economic class, help to resolve material conflicts and other problems with ongoing supervision provided by professionals. One aspect of the parent aide role is total availability to the abusing parent so that the dependency that once rested on the child has been transferred to the lay therapist.

One of the programs described in part I, the SCAN program in Arkansas, is a lay therapy program. According to professionals in the community, this is a highly effective program in which volunteers work with parents and in which turnover among volunteers is minimal. In the experience of this program it has been unimportant to match socioeconomic characteristics of lay therapists and clients, rather the emphasis is on matching the needs of the client with the particular skills of the therapist. There seem to be several key factors in this program's success. Volunteers receive preservice training and ongoing supervision. In addition, they have primary responsibility for their cases and belong to an organization which is totally their own. Thus, unlike parent aides in other programs who act as mere assistants to the responsible professionals, the SCAN lay therapists have both status and responsibility. In addition, each SCAN volunteer works with three or four clients rather than with only one family so that the work assumes a central role in the life of the lay therapist.

While the literature focuses on the importance of meeting dependency needs and on connecting parents to a variety of services, several of the programs visited regard this as only the first step in a well-articulated treatment approach. The underlying view of those who work to meet dependency needs and go no further is that this very process will itself lead to growth and change. However, others feel that once the dependency needs have been met, effective treatment, or reparenting, involves the teaching of a whole new set of behaviors and attitudes that are absent from the parent's repertoire of experience. In these programs, staff is more likely to model, or to discuss, specific child-rearing alternatives to abuse, to teach parents how to play and interact with children, and to teach couples how to listen to and communicate with each other. When therapists have such remodeling goals in mind, they are more likely to be active with their clients, to confront destructive or nonproductive behavior, and to set assignments and tasks in which new behaviors are practiced. Effective problem-solving behavior is then reinforced, validated, or "stroked" so that the parent explores the repertoire of positive adaptive behaviors initially in order to gain the approval of the therapist. Ultimately, the parent engages in adaptive behavior simply because she/he has learned a set of new responses which have proved to be more effective.

Most therapists who take this active approach are careful to emphasize the preliminary need for first meeting dependency needs. Until some of these needs have been met, it is felt that parents simply cannot "hear" the therapist's teachings and are unable to make use of them.

Group Therapy

Polansky, Hally, and Polansky (1974) discuss three types of group treatment techniques: socialization and resocialization groups, parents'

groups, and social action groups. The first type provides an opportunity to meet other families with socializing as the "drawing card." Parent's groups are organized around a more visible point, i.e., all the parents of children in the same day care program. Social action groups attempt to teach advocacy and revolve around issues of service provision. Group therapy in the form of Parents or Families Anonymous are important self-help groups. Polansky, Hally, and Polansky (1974) have pointed out that there are problems with these modes of treatment for neglectful parents who are more depressed and withdrawn and are less motivated to join than are abusive parents.

Three of the programs visited have a group therapy component as one major treatment modality: Children's Trauma Center, Oakland, California; Lehigh-Northampton Counties Coordinated Child Abuse Program, Allentown, Pennsylvania; and SCAN Volunteer Services, Inc., Little Rock, Arkansas. Cases treated within groups developed by these programs are described in part I. The first two programs use co-therapists, whereas the latter program uses a single therapist. All of the groups are designed to encourage active problem solving among the group members and to create a social support network for each member. Group sessions in all three programs take place weekly and group size tends to be six to eight members. All of the programs have a group which is open to men as well as to women, although Children's Trauma Center has additional groups which are for women only. Programs which have a mixed group, which typically includes couples and single women, report no problems with this mix.

Criteria for group therapy spelled out by the programs include: ability to share the therapists with others, adequate intellectual ability in order to allow for verbalization and communication with others, absence of acute psychoses, and a lack of resistance as manifested by explosive behavior which is so strong that it disrupts the group process.

Advantages of the group are described in terms of the energizing function of the group, the relatively greater ease of identifying and understanding destructive interactions and behaviors in others than in oneself, the possibility of ignoring or bypassing a client who is not in a working frame of mind in a given session, and in terms of the supportive functions of the group. Parents are encouraged to socialize outside of group sessions and to act as a supportive network for each other.

Two other kinds of groups were represented by the programs visited. One was the Parents Anonymous group sponsored by the SCAN, Little Rock Program, and the other was the activity groups of the Bowen Center, Chicago, Illinois. Each of these groups is described in part I in some detail.

Parents Anonymous (PA) is seen as an excellent vehicle for socialization, for obtaining a wide range of information about parenting, and for developing a supportive network. PA meetings tend to be confrontive and are felt to be suitable primarily for the more aggressive parents. Individuals who tend to be severely constricted or withdrawn are likely to be frightened by such an approach.

Bowen Center's activity groups, which meet twice weekly for an entire morning and through lunch, are designed to promote the development of social skills and to enhance self-esteem through completion of simple specific craft projects. Because many of the parents in all of the programs lack the social skills necessary for engagement in community recreation groups, e.g., church socials, community center arts and crafts groups, such activity groups are an important resource for teaching recreational skills and developing a sense of pleasure and self-esteem. Such activity groups seem to be particularly useful for individuals of limited intelligence who cannot make use of a group therapy experience.

None of the group experiences is designed to replace the relationship with the primary caseworker who continues to work with the client. The caseworker continues to meet dependency and service needs and eventually begins to confront the client and to make demands for change. This latter process seems to be greatly intensified in a well-coordinated caseworker/group therapy joint effort.

Couple and Family Therapy

Couple therapy, which is most extensively practiced at Children's Trauma Center and to a lesser degree in a few of the other programs visited, is designed to give couples an opportunity to work on their own relationship with a therapist who interprets and points out those aspects of the interaction which are destructive,

as contrasted with those which are positive. Couples are taught to listen to each other, to communicate their needs in a reasonable manner, and to engage in pleasurable recreational activities, both as a couple and as a family. Programs in which the primary intervention is with the mother often find that at a certain point in the treatment it may become important to see the husband or boyfriend. However, when this is not done from the beginning of treatment, the husband/boyfriend is likely to feel that the therapist is already allied with his partner and that his "side" will not be fairly heard. Moreover, working with a couple requires specific skills which have to be taught rather than taken for granted.

Children's Trauma Center, Lehigh-Northampton Counties Coordinated Child Abuse Program, and individual caseworkers in several other programs have done some family therapy. In general, however, this seems to be the least developed and least familiar treatment modality. This is quite paradoxical considering the fact that the primary goal of every protective services program is to strengthen and preserve family functioning and unity. A family therapy approach is sometimes used in situations where there are older children and in which the roles and conflicts within the entire family need to be worked through. In addition, in a very few instances, intergenerational family sessions have been conducted on a short-term basis in order to work through conflicts between parents and grandparents. In general, while grandparents are often omnipresent in destructive interactions with the target family and while programs are acutely aware of these relationships, very little has been done to try to include grandparents in the therapeutic process.

Criteria for Different Treatment Modalities and for Success

In most programs, an individual casework approach is still the primary mode of treatment. Essentially, this is because of lack of resources and lack of training in the use of different modalities. In our view, abusive parents do have intense psychological problems which manifest themselves in their relationships with others. Therefore, they should have the opportunity to actively engage in group therapy and in family or couple therapy. If these services are not available within the abuse program then they should be obtained from a private agency which does provide them but the primary caseworker should serve as a co-therapist. As the Lehigh-Northampton Counties Program described in part I illustrates, such co-therapy promotes a sense of continuity in the treatment process so that there is active give and take in all aspects of the treatment. It also serves as a training mechanism for the caseworker who learns other treatment modalities and for the mental health worker who learns about abusive families. Moreover, it gives the mental health worker the support that is needed if she/he is to become involved with families who are often aggressive and uncooperative.

Neglectful parents whose neglect is a function of limited intelligence, ignorance, or extreme problems associated with poverty are less likely to benefit from psychotherapy. Instead every effort should be made to provide concrete services and a great deal of specific step-by-step education about budgeting, household management, food planning and preparation, and child rearing.

The impact of various treatment approaches and programs has not been measured in any systematic way to date. Some authors have attempted to define criteria for improvement. For instance, Kempe and Helfer (1972) state that as a result of therapy, " . . . at least 75 percent of the children reported as a result of state reporting laws to have been nonaccidentally injured by their parents or guardians should be residing safely in their homes within one year after the report of abuse has been made" (p. xii). Although they present no statistics on how many parents no longer abuse their children after having completed therapy sessions, Kempe (1969) does state that approximately 90 percent of abused children can remain with the parent after having undergone only a brief separation. Indications for separation, however, depend upon the age of the child and the frequency and severity of the injury. In cases of incest, for example, Kempe states that separation is almost always required. A scheme for treatment as proposed by Kempe (1971) is as follows: (1) the child is admitted to the hospital after an incident of abuse, (2) the child is temporarily separated from his parents for protection, (3) a plan for "mothering" therapy is begun to make the home safe for the child's return, and (4) the child is gradually returned to the family. Kempe

has found that intensive care rarely lasts longer than 8 months. However, no statistics are provided to illustrate that generalization.

With few exceptions, most of the treatment programs visited have not been in existence long enough to assess the longer-range impact on clients. Criteria for improvement include stabilization of the immediate crisis and the parents' ability to see the child as a separate individual with legitimate needs, to meet the child's needs and to enjoy interactions with him, to recognize feelings of fear and anger, to make use of resources in the community, to derive support from a marital or psychological partner, and to feel competent and worthwhile. All of the programs visited are able to describe cases in which there have been specific and tangible gains, in which children have been returned home and in which parents function in a more acceptable and more self-fulfilling manner. In several programs the reinjury rate is reported to be as low as 2 percent. This seems to be particularly true in programs in which services and treatment are intensive and contact is more than weekly.

Constraints to treatment of abusive and neglectful families have been discussed in the literature. Confusion and lack of direction in the handling of abuse cases, staff turnover and specialization, and a general rigidity of social service and mental health agencies are all impediments to successful treatment.[5] These problems are discussed in the next chapter.

A report by the Boston Children's Hospital Medical Center (1974) summarizes some assumptions with regard to intervention. Two major assumptions are that outcome of treatment varies directly with the amount of professional energies involved and also with the amount of training and skill of the professionals. Morse, Sahler, and Friedman (1970), in studying abused and neglected children 3 years after hospitalization, found it impossible to relate the intensity of agency intervention to the child's safety in remaining in the home. However, this study did not include a research design that would permit comparisons between groups which were treated by markedly different and carefully specified interventive modes. Gil (1970, 1971*a*) and Newberger (1973) state that effective intervention may depend more on resolving basic problems in the parents' lives such as poor health, inadequate housing, lack of child care, and legal and financial difficulties than on treating symptoms of abusiveness. These conclusions are based on an underlying philosophy about the causes of abuse, rather than on any studies designed to test the hypothesis that concrete service intervention is more effective than treatment.

In our opinion, to stress the importance of social manipulations over the importance of a therapeutic approach, which includes exploration of feelings and teaching, modeling, and practicing of new behaviors is to overlook the very real possibilities for growth and development which characterize many parents. The experience of those in the programs visited strongly suggests that delivery of both concrete and treatment services is crucial and that neither alone is of sufficient value. However, this issue will ultimately have to be addressed by carefully designed research studies.

Duration of Treatment, Volunteerism

Two areas of considerable controversy are the duration of treatment and the effectiveness of court-mandated as opposed to voluntary treatment. In most of the programs visited, families are in treatment for approximately 2 years. However, the range is from 6 months in one public social service agency to 7 years in a private, nonprofit program. In general, programs which have a short-term casework orientation are more likely to emphasize behavior rather than personality change and to offer a more structured form of therapy with emphasis on short-term goals. Programs which offer long-term casework are more likely to emphasize exploration of feelings, reparenting, and personality change. However, even programs which emphasize short-term treatment recognize that there are many families in which the pathology or limitations are so extensive that contact has to be maintained over a period of years rather than months. The length of time a family is known to a program seems to depend primarily on the orientation of the program and the kinds of changes being sought, and secondarily, on the family itself. Despite a program's particular orientation, however, it is generally acknowledged that chronic neglect cases require a longer period of intervention than abuse cases which are apt to make more rapid progress. A large proportion of abusive parents, if actively treated, appear to make marked progress within a 2-year period.

The emphasis on short-term treatment seems also to be a function of funding pressures and of policy decisions that treatment should be short-term. There is some indication that Kempe's (1969) oft-quoted statement that only 10 percent of abusive parents are psychotic has led to an understanding by policy makers that these individuals are not severely disturbed and that therefore they can be helped within a few months period of time. However, absence of psychosis does not imply absence of severe psychopathology and most individuals in the treatment programs visited are in agreement that successful treatment takes considerably longer.

While most programs prefer to work with parents who are not court referred, the overall consensus seems to be that court referral is not an insurmountable obstacle to the development of a therapeutic alliance and that there are parents who become very involved in the treatment process who would never have done so without the authority of the court. It seems that when the parental resistance to the therapeutic service is confronted openly and honestly, when their anger for being forced to come is recognized by an individual who has some real skills in being helpful, the initial resistance can be overcome.

Treatment and Services for Children

As discussed in chapter VIII, therapeutic approaches to children which go beyond day care are almost nonexistent. Among the programs visited, only the Bowen Center and, to some extent, Children's Trauma Center have therapists on staff who have any specific training or interest in working with children. By and large, children are seen in passing and are excluded from the therapeutic process. Yet the descriptions of abused and neglected children make it clear that they are in need of developmental day care and of a therapeutic approach. Children of school age should have a primary worker assigned to them whom they see on a regular weekly basis in order to work through their concerns and anxieties either in play therapy or through discussion. Development of lay therapy programs for children who need a special friend or ally and an occasional treat every bit as much as their parents should be a high priority.

There is also relatively little work with adolescents who are currently abused and neglected or who have been abused/neglected as children. Because it is fairly well established that people who were abused as children tend to become abusive parents, it would seem that an adolescent group approach with an emphasis on working through the abuse experience and on more positive parenting through a supervised work experience in programs such as day care, Head Start, etc., would be important.

Foster home placement is seen by some as therapeutic and by others as a necessary evil to be used only in life-threatening situations. Some staffs seem to feel that all but the most physically brutal biologic parents are better than even the best of foster parents; others disagree. Some programs encourage short-term foster care when they feel that the parents need a respite, with relatively little consideration given to the child's developmental age and the possibility that the separation may be coming at a particularly destructive time. Other programs see foster care as an opportunity for the child to experience some of the benefits of a nurturing relationship so that when the child is returned home she/he will be able to respond more positively to parenting and thus increase the likelihood that the parent will be able to respond more positively in turn. This view of the therapeutic use of a foster home which through its nurturant care teaches the child new ways of relating carries with it the underlying assumption that a foster home should offer the child the maximum in terms of love and affection. This is in direct opposition to the view held by some agencies that foster home parents should not develop a close and intense relationship with the child because such a development leads to difficulties when the child is to be returned home.

Foster home placements are often made in the midst of crisis without adequate time to assess the suitability of the home to the needs of the particular child or to work through the reasons for the placement with the child. All too often, even in the absence of crisis, a crisis atmosphere prevails and children are removed from their homes without adequate discussion or support. Inadequate preparation of children, of the foster home, and of consideration of the mix between the two, leads to multiple foster home placements for children who have already experienced considerable trauma. While every

program seeks to avoid such multiple placements, it is not at all uncommon for children to be placed in three or four different foster homes.

For many children their initial placement in a foster home serves as further confirmation of their own badness. The first confirmation is in the abuse or neglect itself: "I must be really bad to deserve such punishment." The second confirmation comes with the removal from the maternal home: "I am so bad I was sent away." Many children, coming from chaotic homes in which there are no limits on behavior, under acute stress, and with a deep-seated conviction that they are too bad to be lovable, enter foster care with a multiplicity of behavior problems. Without treatment and active intervention in these problems and without massive support for the foster parents it is hardly surprising that these placements fall apart.

Use of foster home placements varies from program to program and is dependent on the emergency and supportive services available in the community, the attitudes of the juvenile court judge, the program's tolerance level for destructive or inadequate parenting, and the availability of what are considered to be quality foster homes. Therefore, great caution should be used in deciding whether a low percentage of children in foster care should be taken as an indicator of program success. Some communities have developed comprehensive emergency and supportive services which enable children to remain in the home while work is initiated and continues with the family. For example, one program, described by Burt and Balyeat (1974) found that through coordinating State, local, and voluntary agencies and through an effective screening program augmented by 24-hour emergency foster home care, the number of children removed from their homes was considerably reduced. In fact, institutionalization of children under 6 years of age was almost completely eliminated. Other communities, lacking money and foster care resources, leave children in their homes and claim a low foster care rate as positive; in fact, many of these children are maintained in their homes under horrendous circumstances.

Either voluntary or involuntary placement in foster care is typically done without legal representation for the child. However, in a few communities even voluntary placements cannot be effected without the child having legal counsel who represents the child's interest and who then serves a monitoring function to ensure that services are delivered as planned and that they are in the best interests of the child.

Often, foster care placements are made with the expectation that they will be short; however, in many cases they tend to be long-term. It is not unusual for children to be in foster care from infancy throughout their entire childhood and adolescence. The treatment orientation of most programs creates a bind, in the sense that when the child is very young and has a good chance for adoption, the program is working toward rehabilitation of the parents. As long as the parents continue in treatment, there is no chance that a judge will consider termination of parental rights. After a few years of working with the parents, if no improvement is evident, it is by then too late for adoption because, realistically, the child is no longer adoptable. Termination of parental rights is a great rarity. Even in cases where the parents are not actively involved in treatment and make only occasional visits to the child, judges are reluctant to terminate their rights.

Just as treatment services are primarily focused on parents, so the whole concept of foster care is more geared to the needs of parents than of children. In most communities, regardless how long children have been in foster care, as long as the parent refuses to permanently relinquish the children they remain in foster care. Children's rights advocates are increasingly demanding that when children are placed in foster care, the specific steps which will have to be taken prior to the return home and the time frame for their achievement must be outlined and an agreement reached with the participation of the court that if these goals are not accomplished the result will be termination of parental rights. This is the only way in which long-term storage of children in foster care can be avoided.

The management of children in foster care and their return to the home is given careful consideration in some programs. Several programs plan for weekly visits between children and their biologic parents and provide supervision during these times. In programs where caseloads are not excessively large, the worker assigned to the family is the same person who participates in these visits. This approach seems to be more positive than one in which the child is assigned to a separate placement worker, who has no relationship with the parents yet who

supervises the visits. When visits are supervised by the parents' own worker, the potential exists that these visits can be used as a learning experience and that they become grist for the therapeutic mill. Most program staff advocate a gradual return of the child to his natural home. Such a gradual return, which includes weekend visits and in some programs visits for up to a month, are used to reacquaint child and parents, to assess the ability of the parents to tolerate the child and to meet his needs, and to test the strength of therapeutic gains. In all too many instances, program staff reported cases in which children were returned to parents after long absences without any preparation. Particularly in cases in which the child is removed in early infancy and returned around the 18 months to 2½ year period in which separation is a crucial issue, children have reacted with feelings of being rejected and loss of self-esteem. Lacking any knowledge that the child is going through a mourning process which is understandable and which is not related to the parents' "badness," parents have reacted with rage, with resulting severe abuse.

In general, it can be concluded that those working in the field of abuse and neglect lack training in child development and lack professional experience with children. Thus, the abused child who has been discharged from the care of a pediatrician only rarely comes to the attention of anyone who is trained to meet his needs and who can help him work through his experiences. The neglected child has virtually no such opportunity at all. Yet all of these children who have already suffered so much should have first priority in terms of services. The Bowen Center which has provided services to children for the past 9 years reports that gains in children who receive therapy are easier to achieve than gains in the parents. It is paradoxical that those who might be the most able to benefit from treatment services are the least likely to receive them.

NOTES

1. American Academy of Pediatrics 1972; Bishop 1971; Gray 1973; Helfer 1970*b*; Kempe 1969 and 1971; Newberger and Hyde 1974.
2. Alexander 1972; Arvanian 1975; Burt and Balyeat 1974; Costin 1972; Foresman 1965; Holter and Friedman 1968*b*; Komisaruk 1966; Penner 1967; Polansky, Hally and Polansky 1974.
3. Alexander 1972; American Academy of Pediatrics 1972; Avery 1973; Bean 1971; Caffey et al. 1972; Cherry and Kuby 1971; Costin 1972; D'Agostino 1972; Galdston 1971*b*; Joint Commission on Mental Health of Children 1973; Kempe and Helfer 1972; Penner 1967; Polansky, Hally and Polansky 1974.
4. D'Agostino 1972; Leivesley 1972; Lukianowicz 1971; Silver et al. 1971; Wooley 1963.
5. Cherry and Kuby 1971; Newberger and Hyde 1974; Polansky, Hally and Polansky 1974; Terr and Watson 1968.

Chapter X — Social Service, Health, Child Care, Educational, and Law Enforcement Systems

This chapter summarizes what was learned through visits to various agencies in the service delivery system of eight communities. While this is a small sample on which to base conclusions, based on a reading of the literature and on conversations with a great many professionals in the field, our impression is that what we saw fairly represents the state of practice.

SOCIAL SERVICES

In most States, the public social service agency is the agency mandated by law to receive reports of neglect and abuse, to provide protective services to the child, and to coordinate resources which can promote family unity. However, it is one thing to mandate and quite another thing to appropriate funds which enable fulfillment of that mandate.

In most public social service agencies it is absolutely impossible to discharge these responsibilities. No caseworker can provide intensive services to a caseload which may range anywhere from 40 to 80 families. In order to permit the flexibility which enables the worker to see families through a crisis or at the beginning of a relationship several times a week if necessary, to see most families weekly, and to see families who are getting ready to terminate biweekly, 20 families seems to be an absolute maximum. Larger caseloads lead to feelings of frustration, helplessness, despair, futility, and ultimately of unresponsive callousness. The story of a worker who could not address herself to the needs of a young boy whose mother had amputated his penis because the worker was so depressed about several of her other families and her work in general, is illustrative of the deadening of emotional response. In fact, it can be said that in permitting such large caseloads and the subsequent deadening of worker responsiveness, society is recapitulating the experience of the child in a home where the responsiveness often is deadened by sustained parental stress and crises.

After caseload size, the next greatest impediment to effective work with families is lack of skill and training. Protective services work is enormously challenging and difficult, requiring an especially high level of skill. In all too many cases, staff of the public agency receives no training beyond an initial orientation and no supervision beyond friendly support. While the emphasis of protective services is said to be the preservation of the family unit, many workers received no training whatsoever in family or couple therapy. Moreover, as discussed in the previous chapter, most have no training in work with children or adolescents and relatively little specific knowledge of child development which they can usefully transmit to parents.

It is one thing for a community to charge an agency to carry out certain functions if the people within the agency have the capability; if they do not, in all too many cases the community is lulled into thinking that the services are being rendered. Social service agencies are generally reluctant to ask other agencies to join them and to help them deliver services. With a few noteworthy exceptions, our impression is that the social service agencies with the least experienced and knowledgeable staff are the most self-protective, i.e., the most likely to keep other agencies away. As a general rule, social service agencies in which at least some of the staff have real therapeutic skills are eager to join with their colleagues in other agencies to implement therapeutic programs. Contractual linkage with a mental health agency can be a tremendous resource for expanding the capabilities of the public agency. For instance, under contractual arrangement the mental health agency can develop group therapy programs for abusive parents and protective services caseworkers can serve as co-leaders. In this manner, the protective services unit develops a new

capability and some staff receive training in a new modality. The Lehigh-Northampton Counties Coordinated Child Abuse Program described in part I provides an outstanding example of the benefits to be derived from a contractual arrangement between a mental health center and a public social service agency in terms of the development of a group therapy program and staff development.

In our opinion, all efforts to provide technical assistance and staff development are misdirected unless and until caseload size becomes manageable. However, efforts to reduce caseload size should not be based on policies which emphasize short-term, 3-6 month treatment. In our view, there is sufficient evidence to suggest that substantial gains can be made only after 1-2 years of intervention. In all too many cases, "crisis intervention" is a poor substitute for creating the opportunity for the changes which can occur with a more long-term intervention. Once an agency has achieved a manageable caseload, staff development is the next step. It should be clear, however, that the installation of better management and administrative procedures may make more effective administrators, but that this is in no way synonymous with an effective supervisor who can discuss techniques, review cases, and make suggestions on what to say and do, who can act as a co-therapist, and who can expand his staff's repertoire of techniques and skills.

Creation of a special protective services unit(s) within the agency helps to establish an esprit de corps and to identify that group out of the entire agency staff which is most in need of intensive training and ongoing supervision. It is especially important that the workers within protective services establish a sense of unity and provide each other with support and recognition. Moreover, these workers need to function as a unit so that they can exchange information about resources and about clients. It is not at all unusual to speak to a worker and find that she does not know that a particularly effective day care program to which another worker refers is even in existence. Similarly, two workers may have clients who live near one another and who could benefit from a social contact, yet neither worker knows anything about the other's family. Unit meetings, if they are not exclusively devoted to agency policies and administrative procedures, can serve a creative group problem solving function.

One problem with protective services seems to be that the staff is expected to know and use a wide variety of treatment modalities with insufficient training in some and no training in others. Even well-trained mental health professionals with advanced degrees do not work with children, adolescents, and adults; with individuals, couples, families, and groups. Serious consideration should be given to development of protective service units in which there is some specialization. Each unit should have a couple of people who are really skilled and interested in working with children and adolescents. Similarly, each unit should have workers who have recognized competencies and preferences for working with couples and with families in addition to individual casework. Case assignment should be on the basis of a match between problems posed by the family rather than on the basis of a simple rotation system.

Even with the best staff and under the best of working conditions, emergency shelters or receiving homes, adequate foster homes, and residential treatment centers are a necessity. In all too many communities there is no adequate facility to provide for children who must be placed on an emergency basis. In those communities which have such a facility and where the facility is designed to work intensively and supportively with children in crisis until an adequate placement can be made, everyone is in agreement as to its importance.

As discussed in the preceding chapter, all too often foster home placements must be made without any time to plan for a match between the problems and the needs of the child and the special characteristics of the foster home and its own members. By and large, foster families take in extremely difficult and emotionally damaged children without adequate ongoing support or training. Foster home placements "blow up" in a very large proportion of cases because the children are too disturbed and the foster parents too unprepared for the problems they will encounter. Often, children are placed in homes which are considered by protective services staff to be poor or unsuitable because there are no others. There seems to be a widespread fear of trying to change attitudes or behaviors of foster parents because they may ask that the children be removed. Almost invariably, the social service agency supports the foster parents at the expense of the natural parents and the child.

The frequency and circumstances of visits between the child and his natural parents are extremely variable, depending not only on the parents, but on the agency as well. Some agencies are so understaffed that they do not take parents for more than monthly visits; others are more likely to encourage weekly visits. If the return of the child to his home is a real and realistic goal, it is difficult to understand how monthly visits can even begin to help parent(s) and child(ren) work out a modus vivendi, to say nothing of the fact that the returning child and his parents may well seem like strangers to each other. In many agencies, the child is assigned a new worker when foster care placement is made. This means that the visits are supervised by the foster care worker and not by the parents' worker, so that there is no emphasis on helping the parents to learn something from the interaction. Some social service agencies do not work with the natural parents at all if all of the children are in foster care. In such cases the pretense of working to preserve family unity should be dropped. It seems to be the most cynical form of hypocrisy to preserve a protective services rhetoric while doing no work with parents whose children are in placement.

The high turnover rate, often more than 100 percent in any given year, and the burnout of protective services workers is well known. Yet there are public social service agencies in which there is a lack of turnover and discouragement. In every instance this seems to be related to manageable caseloads, effective staff organization and support, and opportunities for staff development.

HEALTH SERVICES

The three types of agencies discussed in this section, hospitals, public health, and mental health, have all been discussed in previous chapters of this report. In this chapter we present a summary of their functions vis-a-vis abused and neglected children and their families and the constraints to their effective use.

Hospitals

As discussed in chapter VI, the primary function of the hospital is in case identification and reporting. There seems little doubt that effective identification and reporting takes place only in hospitals which have developed special mechanisms and procedures as well as a climate of understanding and knowledge. Effective hospital response to child abuse and neglect does not seem to be something which simply happens, it takes planning and ongoing commitment to the problem.

Within the hospital there must be coordination among all of the different services and this should certainly include coordination between obstetrics and pediatrics, as well as between other medical and social services. If the hospital is not a general hospital but a children's hospital, the latter should take responsibility for developing close working relationships with and a training program for feeder maternity hospitals or services.

In our opinion, a hospital in which there are no recognized procedures and no recognized individuals with specific training in child abuse cannot be dealing adequately with the problem. One important aspect of an adequate response to the problem involves the need for weekly meetings between the hospital team and the public social service agency. While the social service agency may show marked resistance to this kind of case sharing, we believe that effective coordination of services is only possible in the case of such joint staffing and that the hospital should take the lead in promoting such a relationship.

Public Health Department

The function of public health nurses and the tremendous asset which they represent in child abuse and neglect cases were discussed in the previous chapter. Weekly visits by a public health nurse can be tremendously supportive and educational to the mother and, in some cases, determine the outcome of the decision to leave a child in his home. That is, knowing that the public health nurse will see the children and check on them weekly, particularly in the case of very young children, sometimes makes it possible to leave children in the home who would otherwise have to be removed.

Public health nurses should participate in interagency staffings and their referrals to the public social agency should be taken very seriously. In many cases, public health nurses

are the first to become aware of children in danger or living under harmful conditions. The public social service agency and the public health agency should have a working relationship which is satisfactory to both agencies and this relationship should be viewed as an important partnership.

Mental Health Centers and Child Guidance Clinics

While hospitals and public health departments are increasingly actively involved in identification and delivery of services to abusive and neglectful families, mental health centers and child guidance clinics generally ignore the problem.

Mental health professionals are accustomed to working with individuals who are "motivated" and who actively seek help. They are not in the habit of making home visits, of reaching out and calling people who miss appointments, of providing flexible appointment times, of continuing past the "50 minute hour" if the situation demands it, and of 24-hour on-call availability. Mental health clinics do not have available to them the range of concrete services which are important to abusive and neglectful families. Mental health staff generally structures relationships so that one treating individual, rather than the agency or the unit, is seen by the family as their life line to help; this is contraindicated among many abusive and neglectful families which need to feel that there is an entire group of individuals who stand ready to provide help. Mental health staff finds the issue of confidentiality particularly difficult and tends to be especially reluctant to report parents, even though such nonreporting is not only illegal in many States but is also felt by many to be antitherapeutic in that it tends to support the parents' position of denial.

The experience of most communities is that referral for treatment to a mental health clinic is nonproductive. The staff is neither trained nor organized to provide services to these families and the parents fail to follow through beyond a couple of sessions. In most cases, a referral to the mental health clinic seems more of a ritual than a solution that anyone expects to be effective. No one expects these referrals to work and, in fact, they usually do not. In addition, there is the problem that mental health staff tends to work in isolation so that while they may be aware of their patients' progress, they have little capacity to assess their patients' functioning vis-a-vis the children. As discussed in chapter IX, this can sometimes lead to tragic consequences if, for instance, a child is returned prematurely to the home on the testimony of the mother's psychiatrist who has no firsthand data on the mother-child relationship.

The mental health clinics which are an exception are those in which staff has taken a particular interest in the problems of abusive and neglectful families and has developed responsive modalities for working with families. The interested reader is referred to two programs, described in part I, in which the mental health clinics play a major role in the treatment process. These two programs are the Lehigh-Northampton Counties Coordinated Program and the Laramie, Wyoming Child Abuse Treatment Team. In the first program, the mental health clinics in each county provide therapists who work as co-leaders with the public social service agents in the groups and who also provide some family, couple, and individual therapy. Mental health therapists and social service caseworkers share sessions, participate in joint staffings, and in general are involved in an active partnership which goes far beyond mere referral. In the Laramie program, the mental health center staff acts as part of a treatment team which has representation from all agencies involved in service delivery so that again the partnership goes well beyond referrals. Moreover, the staff of the mental health center does most of its work with abusive and neglectful families in the home so that missed office appointments and the resultant frustrations are bypassed.

In our search for child abuse and neglect programs under mental health auspices, we discovered less than a handful of operating programs. In general, mental health centers make no special provisions for the treatment of these families under the rationale that "we treat them just like we treat everyone else," with the result that, by and large, they do not provide services to families with a major problem in this area. The widely accepted myth is that the families are not amenable to psychotherapy and since, in general, it is true that they are not amenable to the psychotherapy as practiced within mental health clinics, the myth has become a self-fulfilling prophecy.

CHILD CARE AND EDUCATIONAL INSTITUTIONS

Included in this section is a discussion of the role and status of child care and child development programs for preschool children and of the school system.

Child Care Services

Virtually everyone agrees that a quality day care program can serve as a major source of relief to parents, as a therapeutic intervention into the pathology of the abusive parents, and as a lifeline to abused and neglected children. Day care varies tremendously not only in terms of what is available in the community but also in terms of what is reimbursable by social services. In some communities, social service pays for a maximum of 1-2 hours a day, in others for a full day. In some communities, day care means no more than babysitting by a licensed day care mother. Communities which have a special day care program for children with developmental difficulties have an invaluable resource for children.

In general, coordination between day care staff and social service staff is minimal. Often, little more is done than to exhort day care center staff to report any new bruises on the child. However, when day care staff is included as part of the treatment team, they can make an invaluable contribution not only in terms of working with the child but also in extending their acceptance and their knowledge of children to the parents.

Day care center and Head Start staff need training to ensure identification and reporting; they also need to feel that they are part of an ongoing team which supports their work with abused children and their parents. These tend to be very difficult clients and without special training and ongoing staff support it is unlikely that the families can be effectively served.

Educational Systems

In most communities, the school system is not actively involved in the identification of abuse or in service delivery to abused children. In a few communities, a school social worker or nurse has taken the lead in initiating and maintaining contact with social services but, by and large, school people seem reluctant to become involved, fearing the consequences of reporting both for the child and for themselves.

It seems apparent that, like hospitals, every school district should have a SCAN team which can provide consultation to individual schools on a case-by-case basis and can take responsibility for calling in the parents and for making the report. It is hardly surprising that principals who are totally untrained in this area are reluctant to confront parents with accusations of abuse and neglect and that they simply avoid the issue.

LAW ENFORCEMENT AND JUDICIAL SYSTEMS

Included in this section are the functions and services of the police, attorneys, and juvenile court judges.

Police

In some communities, the police are one of the mandated receivers of reports; in other communities they are the only ones who have the right of entry into a private home to take an endangered child into custody. In many communities, the police are the only agency with a 24-hour response capability. In some communities, especially if criminal prosecution is being considered, the county attorney expects the police to carry out the investigation on the grounds that social service staff is not trained to gather evidence of legal value.

Whether it has been to request that police go to a home and remove the children or to request police assistance in holding a child whose parents want to remove him from a hospital, every abuse and neglect program has contact with the police. When the police have had training in work with abusive families, they tend to be very supportive and helpful. Without training they tend to be authoritarian and to evoke unnecessary hostility in the parents and fear in the children.

Attorneys

County attorneys play a very important role in that they not only decide which, if any,

families to prosecute in criminal court, but also whether or not there is enough evidence on a case to stand up in court. The larger social service agencies have their own court department which provides legal consultation to the agency and advises the agency staff on whether there is sufficient evidence for the agency to obtain legal custody and/or to remove the child from the home.

In communities in which the child abuse program has effective means for delivery of services and has a strong positive relationship with the county attorney's office, prosecution in criminal court is less common. However, some enlightened attorneys feel that in some cases there is no alternative because they know that social services lacks the capability of working with the family. Other attorneys view abusive parents as criminals and are not open to a different point of view.

Attorneys who represent parents are, by definition, trying to prove that the parents are adequate. Their sole function is to make sure that the parents' rights are upheld at all costs. Attorneys who represent children are relatively rare. Where such individuals exist and actually make an effort to represent the best interests of the child, they serve as an important reminder that the best interests of the child are at times not synonymous with the interest of the parents or of the agency. A child advocacy approach which emphasizes the rights of the child and the need to re-review cases of children who are in foster care and which monitors the actual delivery of services ordered by the judge is rare but of great importance.

Juvenile Court

Juvenile court becomes a resource when the social services agency feels that children ought to be removed from their homes or in cases in which the agency is given custody so that even though the children remain in the home, the parents have to account for their behavior to the agency. In some communities, the court is also used for therapeutic purposes; the judge spells out expectations of what has to be accomplished if the child(ren) is to be returned or is to remain in the home.

An informed and sympathetic juvenile court judge can be an invaluable resource and backup to a program which is trying to deliver services to abusive and neglectful families. There are times in which the authority of the court can be used therapeutically in a highly effective manner. A juvenile court judge who is willing to accept recommendations and to order day care, continued treatment, and other services as conditions for keeping children in the home is an invaluable therapeutic ally. All too often, judges do not see themselves in such a role and are only willing to consider hard evidence as part of their deliberations regarding removal v. nonremoval. They do not feel that setting conditions for maintaining the child in the home or for returning the child is appropriate and they make it exceptionally difficult to remove a child. If the judge is willing to remove the children only under the most extreme conditions and the court's authority cannot be used to promote cooperation, programs are left without any recourse if parents refuse to cooperate.

A close collaborative relationship between the abuse program and an informed juvenile court judge is extremely important. Ideally, the program, in recommending removal of a child from the home, works out a set of expectations with the parents as to what changes have to occur in the next 6 months. These expected changes are discussed before the judge and are agreed upon by all parties. When the court does its 6-months review, it asks for a review of the progress made. If the goals have been met, the children are returned to the parents; if the goals have not been met, the children must remain in court custody but the judge should set a limit on the amount of time which will be allowed prior to a consideration of termination of parental rights.

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Each of the systems and institutions discussed in this chapter has a vital role to play in the effective management of child abuse and neglect cases. Selection of staff within each agency or institution, training of these key staff within agencies, development of teams within large agencies, and/or selection of representatives to interagency teams are all a vital part of a coordinated effort. In our view, every agency should have a team, or at least a person, who has had training in child abuse and neglect and who relates to such individuals in other agencies. No one, including juvenile court judges and county

attorneys, should be exempt from a brief but intensive training. Every public social service agency should maintain collaborative relationships, beyond referral, with other agencies which can complement, supplement, and extend the range and variety of its services.

A community-based team consisting of representatives of all of the agencies and institutions discussed in this chapter is a critical component of an effective community response to the problem of abuse and neglect. The team should staff and review difficult cases, plan for the development of new services, take responsibility for community education efforts, and work to ensure that all of the agencies represented are providing necessary services. It is particularly important that community team members be of sufficient stature within their own agencies to allow them to speak for their individual agencies on matters of policy and service delivery.

Chapter XI – Summary, Conclusions, and Recommendations

Our review of the literature and our site visits to the eight programs, as well as to public social service agencies, mental health centers, hospitals, schools, day care centers, juvenile courts, and attorneys in the eight communities served by these programs, have left us with specific observations and recommendations relating to child abuse and neglect and to the services designed to help parents and children.

In this chapter, we highlight and summarize those issues discussed at various points in the report which we feel are of particular importance and offer recommendations for policy and practice.

DEFINITIONS

- Programs should develop operating definitions of abuse and neglect which take into account the child's age and the location and severity of the injury. In addition, such definitions should provide a clear statement as to what comprises a minimal level of acceptable care in the areas of health, nutrition, housing, education, and supervision, and the extent of bruising which will be regarded as nonabusive.

- Such operational definitions should be incorporated into State laws so that they can serve as the basis of a clear statement to parents and to other caretakers as to what is and what is not against the law. At present, the laws tend to be vague, not providing sufficient clarity as to what are and what are not acceptable "omissions" and "commissions" in child care. For instance, while many State laws mention health practices, they do not specifically state whether parental refusal to allow immunization of children 0-5 years (on other than religious grounds) constitutes neglect of the children's health care or not.

REPORTING AND INCIDENCE

- Reporting by professionals increases when they have ready access to a team which provides them with consultation and support and which has provided them with an initial orientation to the importance of reporting.
- Reporting increases when the community feels that something positive and appropriate will be done and when the mechanisms for reporting are clearly understood and well publicized.
- Incidence studies are fraught with methodological problems which include problems of definition, sampling base, and underreporting. Thus, current estimates of incidence are likely to be grossly misleading.

CHARACTERISTICS OF ABUSIVE/ NEGLECTFUL PARENTS

- Demographic variables tend to be so confounded that there is little sense which can be made of the interrelationships among income, single parent status, occupation, education, family size, age of mother at first birth, and ethnic status. Even a very large-scale study which could partial out the contribution of each of these variables would be vulnerable to sampling error, as low-income families are more likely than high-income families to come to the attention of both service providers and researchers.
- Sufficient data exist to support the view that child abuse occurs in middle- as well as in low-income families, in intact as well as single parent families, in caucasian as well as in ethnic minority families, in small as well as in large families, in older as well as in younger families. Neglect seems to be more clearly related to income and factors associated with income than does abuse.

- Abuse is the result of an interplay between psychological, social, and chance factors. There seems to be considerable consensus among practitioners regarding the dynamics of abuse. Parents who have unrealistic expectations of the child based on their own needs and who lack knowledge of child development and child-rearing skills, parents who have themselves been abused or who have experienced only criticism and lack of nurturance in their own childhood, parents who have a low sense of self-worth and a feeling of overall helplessness in terms of getting their needs met or in terms of coping with day-to-day living, parents who live under conditions of acute relationship tensions, and parents who are isolated and lack a supportive network, are prime candidates for the role of abuser. Abusive parents are not detached from their children, rather they tend to be overly attached to their children or to at least one child in a manner which does not allow them to see that child as a separate individual with legitimate needs. In the context of a history of frustration and an inability to gratify dependency needs, the child becomes a need-gratifying object who is doomed to fail in this role not only because this is inherently not a role that infants can fill but also because the child as an extension of the parent is also seen as bad and unworthy.
- It is important to understand that the dynamics of abuse as summarized above are derived from the experience of practitioners and are not well documented by research. The primary reason for this is that most of the studies to date have been poorly designed and lack a comparison group. It is simply not enough to make statements about the proportion of abusive parents who exhibit this or that characteristic without comparable statements about the proportion of parents in a non-abusive demographically comparable population who exhibit the characteristic in question.
- The *dynamics* of abuse have received more attention than have *structural* variables. Given a crisis, and the dynamic conditions necessary for abuse, it is unclear whether abuse would occur in the absence of certain structural ego defects. That is, poor impulse control and a deficit in object relationships may well be necessary conditions of abuse. In addition, impairments in reality testing, in the thinking processes, and in the executive and planning functions of the ego seem to be characteristic of many abusive individuals.
- Most of the abuse literature focuses on the characteristics of the parents or of the children, there is relatively little work on parent-child interaction. It may well be that abuse lies neither in the parent nor in the child, but rather in the relationship between them.

CHARACTERISTICS OF ABUSED/ NEGLECTED CHILDREN

- There is no solid evidence to suggest that abused children are more likely than other children to have physical or emotional problems which precede the abuse and act as a triggering mechanism. In a large proportion of cases, the abused child was not premature, colicky, hyperactive, or either physically or mentally deviant.
- The theory of the "identified' child is largely unproven and potentially dangerous. Cases are common in which more than one child in the family has been abused or in which the child who is most disliked is spared and another child is abused or killed. The danger of the identified child theory is that protective services workers do not routinely require a physical examination of all the children in the family where one child has been abused because they have been taught that "usually" only one child is abused. In a family in which one child has been abused, all of the children should have a complete physical examination.
- The consensus seems to be that abused/ neglected children are severely damaged in terms of their ability to function adaptively and that if intervention does not occur at a very young age, the damage may well be permanent.
- These children are most often characterized as unable to relate to others, unable to experience pleasure, aggressive, fearful, and delayed in reaching their developmental milestones.

IDENTIFICATION, CASE MANAGEMENT, AND TREATMENT

- Abusive parents are most likely to accept services and to form a positive therapeutic relationship at the point of crisis. Therefore, it is often particularly important that the worker assigned to a case continue with that case throughout the treatment process. Program models in which the responsibility for intake, case management, and treatment are each vested in a different staff member may appear functionally efficient; however, they do not seem to be as effective in terms of treatment outcomes as are programs in which one person fulfills all three functions.
- If transfer from one person to another is unavoidable within the design of the program, there should be adequate time for overlap so that the worker who has already established a relationship with the parents can assist in the transfer of that relationship to the next worker. For instance, if a protective services worker makes a referral to a mental health agency and if the new therapist is to be the primary source of contact, the protective services worker should effect the transfer of the client in person and should participate in the first few sessions between the client and the mental health worker.
- In the first contact between client and worker, the worker should be absolutely honest and straightforward about his/her role and about the changes that have to occur which affect the parenting of the child, supportive of the parents' desire to do well by the child through concrete reference to those aspects of the parenting which are sound, and able to recognize the parents' feelings of fear and needs for assistance.
- In many cases, confrontation over the issue of abuse itself is counterproductive and only serves to strengthen the parents' denial. Rather, the focus should be on the difficulties the parent is having in her/his life and the difficulties which the child presents and what the worker can do to help improve the situation.
- A plan should be devised with the parent in terms of services which can be made available. Every effort should be made to inform the parent of the purpose of each of the services and of what the parent can expect. Resistance to use of any particular service which is felt to be beneficial should be handled by requesting that the parents "try" on a short-term basis and then discuss the merits or nonmerits of the service.
- In programs which rely on a variety of services in the community and which do not have these services under one roof, every effort should be made to personally introduce the parent to each service provider. The worker's participation in the parents' first contact with day care, with public health nurse, and with homemaker, can mean the difference between acceptance and rejection of the service.
- So long as the parent continues to use a service which is part of a treatment plan and so long as the parent has not been discharged from the program as stabilized, the worker should maintain at least monthly contact with other service providers in order to monitor the progress of the parent in the use of the services. The issue is not only whether the parent is or is not using the service, but also *how* she/he is using it. Day care staff, public health nurses, and homemakers can all share important observations with the worker as to how the family is functioning and what further goals need to be accomplished.
- If the children are removed from the home as part of a voluntary agreement between the parents and the social service agency, there should be a very specific agreement as to what work the parents need to do in order to prepare for the children's return and the timeframe in which this is to occur. If, when the agreed-upon time comes the parent is still not ready, the social service agency should take the case to juvenile court and should invoke the authority of the court to assist in the development of a new therapeutic contract and timeframe for achievement of goals. If this new contract is also not honored, termination of parental rights should be seriously considered and pursued. Regardless of the needs of the parents, children should not be placed in long-term storage in the blind

hope that the parents may one day, in the distant future, provide an adequate home.

- If the children are removed against the parents' wishes, the conditions of their return should be clearly spelled out in operational terms so that when the case is reviewed the court will have an informed base from which to make a judgment as to whether the changes have or have not been made. The contract between the program and the parent(s) should be made with the juvenile court and should be referred to frequently during the treatment process. Besides allowing for a therapeutic use of the authority of the juvenile court, this joint planning helps the parent to achieve a sense of mastery over her/his own destiny, promotes the use of the organizing and planning functions of the ego, promotes a therapeutic alliance between parent and worker, and provides the parent with the opportunity to enjoy recognition of real gains.

- It should be apparent from the above that removal of children from their families should in no way end program treatment efforts with respect to the parents. If the parents are so hopeless that no one can work with them, then there is no reason to expect things to get better and the only solution is termination of parental rights.

- Transfer of placement cases to a child welfare worker is counterproductive and serious thought should be given to program organization which allows protective services workers to continue with all family members even when a child has been placed, rather than to transfer the family or the child in placement to another worker.

- Visits with children in out-of-home care and eventual returns should be planned and executed with great care. The return of a child to his home requires not only that the parents have made agreed-upon changes and progress, but that there has been a systematic plan for visits of longer and longer duration and that the parents' feelings in terms of their own abilities to cope have been carefully explored. The return of children, who have been inadequately prepared for their return and who regard the parent(s) as a stranger, is harmful and sometimes dangerous.

- Whenever possible, visits between children and their natural parents should be in the company of the primary worker as these visits should be part of the therapeutic process. When the worker takes part in the visit, she/he is able to discuss specific incidents and feelings around them and to model alternate forms of behavior. Participation in these visits allows for therapeutic discussion of specifics rather than of vague generalities to which many parents cannot relate.

- While the timing of the removal of a child from his home is often not under anyone's control, in the sense that it reflects an emergency situation, the return of a child to her/his home can be planned and should be carried out with great care. In addition to considerations about the parents and their positive movement, the developmental age of the child should be very carefully considered. Separation of the child from a foster home in which he is thriving, during the period of maximal separation anxiety (approximately 6 months to 2 years of age), may very well not be in the child's best interest.

- The therapeutic relationship with the family should not be terminated as soon as the child is returned to his home. This is likely to be a period of considerable strain for the parents, of very active testing by the child, and of very great stress for the child. If anything, the worker's active involvement should be increased for at least 3 months following a successful return.

- During the time that a child is in foster care, the primary worker who is known to that child and to his natural parents should meet with him weekly to allow him to discuss his feelings and concerns. This weekly visit should include time with the foster parents to talk with them and to provide them with the support which is necessary to protect the placement. It is not enough to ask generally how things are going and to be told "fine." Rather, problems particular to the child should be probed and discussed and alternative ways

of handling difficult behavior should be explored.

- Children of elementary school age and older should not be excluded from problem-solving sessions. Children who are told to "run and play" while grownups plan their lives are only made anxious and mistrustful. Children also need the opportunity to work on their feelings and their behavior and should be seen in a regular weekly session.
- People working in abuse and neglect programs need training, direction, and support if they are expected to work with children and with families. Many workers in this field have received no training in child development and have had no therapeutic experience with children, with adolescents, or with families. Yet, this is a field which demands work with children and with families and not with individual adults.
- Many abusive parents can derive considerable benefit from participation in a group. The group serves an energizing and supportive function and should be led by an individual who has had training and experience in group therapy. If this individual is not the primary worker, the primary worker should participate in group sessions so that there is a flow of information and a sense of continuity between individual and group sessions.
- Parents of average intelligence, who are not massively resistant or hostile, and who are not so needy that they monopolize all attention, can benefit from a group experience. A group can be for couples, for single parents, or be mixed without impairment of its effectiveness. Socializing among members and development of a mutual support system seems to be an important feature. Optimal group size seems to be between 8-10 clients.
- Differences in impact between a Parents Anonymous group and a professionally led group are not clear; many of the benefits ascribed to each are overlapping. Ideally, a community should have both available but, if this is impossible, every effort should be made to develop one or the other.
- For parents of more limited intelligence or for those who are unable to share in a group setting, an activity group can be of great value. Emphasis on completion of simple projects, sharing meals and recipes, and household management and child care issues can be very helpful. Such a group does not replace a group therapy experience and is intended for a different set of clients.
- A family therapy approach to abusive families has not yet been developed. Within mental health in general, family therapy is relatively new; therefore, most communities do not yet have anyone who is well trained in the use of this modality. Because the dynamic tensions in abusive families are often so extreme and because so many abusive families are characterized by destructive relationships between parents and grandparents, it seems that use of a family therapy approach to abusive families could represent a very significant contribution. If the primary caseworker is not skilled in family therapy, she/he should participate in family therapy sessions conducted by the family therapist.
- Husbands/boyfriends should not be left out of the therapeutic work; when they are left out they often sabotage the treatment. Moreover, their exclusion from therapy does little to promote their own improvement or significant change. Because relationship stress is one of the root dynamics of child abuse, it seems clear that every effort should be made to include both psychological partners in the treatment.
- Individual casework should be used as a sole treatment modality only for those individuals who are living totally alone with very young children and who cannot make use of any group experience. In most cases, the individual casework relationship should be one key aspect of the treatment plan in addition to ongoing participation in group, family, or couple therapy.
- Individuals working with abusive/neglectful families should have the opportunity for weekly supervision in the form of case conferences designed to constantly upgrade the level of treatment skills and techniques. At group supervisory meetings, there should be a continual collegeal questioning of treatment interventions, interpretations, and approaches. Alternative approaches and interpretations and their possible consequences should be explored so

that the therapeutic work with a client is based on informed choice rather than on lack of knowledge of alternatives.

- The majority of abusive parents, if they exhibit the major dynamics of abuse, need not only concrete services but also therapeutic intervention. Services alone will not help them work through their sense of low self-esteem and their pathological fusion with the child.
- In most abuse cases, treatment can be viewed as a two-phase process. The first phase involves linking the family to services and establishing an initial therapeutic relationship with the primary worker. The focus of this early phase in the relationship is to establish a sense of trust and of support. The worker should serve the parents as the good parent she/he never had and provide gratification of dependency needs. As soon as this basic alliance is established, the parent is ready for the second phase: participation in additional treatment modalities and new learning about her/himself, about child development and childrearing, and about relationships with others.
- In general, problem-focused goal-oriented therapy addressed to changes in behavior seems to be more effective than is a general exploration of feelings and underlying attitudes. This does not mean that feelings are to be ignored but rather that they are to be grounded in specific experiences. Modeling and demonstration of behavior by the workers appear to be particularly effective. For example, parents can be taught to look for alternative means of discipline if the worker models this kind of problem-solving behavior in interactions with the parent and with the parent and child.
- Positive reinforcement for small gains is especially important and should never be understated. That is, a worker should never assume that a parent does not need to have small gains explicitly acknowledged and praised.
- Neglectful parents who exhibit the dynamics of abuse should be treated within the same treatment modalities as are abusive parents. Neglectful parents whose neglect is borne of ignorance, low intelligence, and/or extreme apathy should be helped to achieve their optimal level of functioning by means of concrete services. Highly specific step-by-step instruction in budgeting and household management can be especially effective.
- In the case of abuse, the consensus seems to be that active treatment should involve at least weekly contact, continued for 6 months to 2 years. Neglect cases usually take far longer; most workers agree that some families require support and ongoing supervision for a period of many years.
- Caseloads should be no greater than 15-20 families if the worker is to have adequate time with clients and with service providers and for supervision and upgrading of technical skills.
- Treatment can be successfully carried out by mental health professionals, by lay therapists, or by protective services workers. Relevant training, ongoing clinical supervision, caseload size, frequency of client-worker contacts, and responsiveness to client needs are more important than is professional training. A well-trained lay therapist who has ongoing supervision, sees each family at least weekly, and is able to visit in the home and provide access to concrete services is likely to be more effective than is the psychiatrist who sees the family only once and then rejects in-office visits, or the protective services worker who sees families monthly, responds primarily to crisis situations, and provides very little ongoing clinical supervision.
- Treatment services for children are underdeveloped. Every abused and/or severely neglected child should have the opportunity to express his/her concerns on a regular basis. In most cases, such contact should be weekly and should not be left to chance encounters or occasional visits to the family home.
- In the case of school age children, there should be ongoing regular bimonthly contact between the child's worker and the school social worker or guidance counselor.
- Preschool abused and severely neglected children should be placed in developmental day care programs which have a strongly

therapeutic and stimulation-oriented approach. High quality therapeutic day care can do much to overcome many of the problems with which the child initially enters. All too often day care is viewed primarily as a relief for the parent without adequate consideration for the quality of day care required by the child and his developmental needs.

- Day care for abused children can also play an important role in the treatment of the parents. The parent learns that the fusion between her and the child can be replaced with a healthier experience of herself as a separate individual who can engage in activities which are fulfilling so that the child becomes less of a need-gratifying object.
- Adolescent children who have been abused or who live in a home in which their siblings are abused should be offered a special group experience in which the focus is on undoing the effects of the experience and on providing more benign and appropriate models for later parenting.

SERVICE DELIVERY SYSTEMS

The Public Welfare or Social Service Agencies

- Every public welfare agency which is responsible for protective services should either be able to deliver the case management and treatment services discussed or to contract for these services with other agencies in the community.
- In addition to traditional income maintenance and child welfare services, every public agency should have available to it the services of public health nurses, day care centers, and homemaker agencies. These services not only provide relief for parents and protection for children, they can also be used dynamically as key features of a treatment plan designed to produce real changes in the functioning of the family.
- Every public social service agency should have a specialized child protection unit or worker; protective services work requires a particular set of services and training. Eligibility workers or generic child welfare workers do not have this necessary training or experience.
- As no single agency can have under one roof all of the necessary services and professional expertise, the public social service agency should take the lead in organizing a child abuse and neglect team which participates in case planning and case review and which assists in the task of community education. The individuals who represent their agencies on this team should have sufficient authority to commit their agencies in terms of policy, planning, and the delivery of services.
- The public social service agency needs to develop systematic procedures for creating, maintaining, and updating resource files, for maintaining linkages with other service providers, and for monitoring quality of purchased services.
- Public social service agencies need to devise mechanisms by which to reduce worker turnover and "emotional burnout." The maintenance of an abuse unit which provides peer support, which maintains caseloads of no more than 15-20, and which provides for active supervision, and activities other than direct work with abusive families, e.g., working with resources, participating in a speaker's bureau, will enhance worker satisfaction and effectiveness.

Hospitals

- Any hospital which admits children should have at least one physician and one social worker or nurse who take responsibility for educating and alerting others to possible signs of abuse, who are versed in appropriate procedures, who provide consultation and support to other professionals, and who maintain a liaison with the public social service agency.
- Hospitals which have no such team are very likely to be underreporting cases of abuse and neglect. In virtually all hospitals which have implemented such a team, the rise in reporting has been sharp and dramatic.
- Hospitals with a psychiatric department have the capability of going beyond case

identification and should give serious consideration to the development of a treatment unit, so that severely abused children and their families can have continuity of physical and mental health treatment.

Mental Health Agencies/Child Guidance Clinics

- While in most communities there is considerable expertise within these agencies regarding child therapy, group, family, and couple therapy, this expertise is not used on behalf of abusive families.
- Mental health service delivery, which typically includes fixed, in-office, 50-minute appointments and which offers no concrete services and no followup in relation to missed sessions, is not compatible with the treatment needs of most abusive families.
- In most cases, referrals to a mental health agency which has no abuse unit and no staff training in work with abusive parents are simply nonproductive.
- Mental health staff and protective services workers in the public agencies could work together to the mutual benefit and training of staff at both agencies. Group and family co-therapy modalities represent an excellent vehicle for such collaboration and joint development. Through such a co-therapy approach protective services caseworkers can upgrade their therapeutic skills and techniques and mental health workers can gain experience in working with difficult, demanding, and often hostile families.
- Case investigation and case management seem clearly to be within the domain of the public social service agency with input and cooperation from many other agencies. There is considerable controversy over whether treatment of abusive families should be the responsibility of the public social service agencies or of the mental health centers. Those who advocate treatment by the public social service agencies point to the mental health centers' lack of responsiveness, unwillingness to provide outreach services, and the negative effects of the therapeutic alliance between therapist and parent which sometimes leads to a dangerous overestimation of the parent's ability to parent. The best argument in favor of these advocates against referral to the mental health centers is that, by and large, because of the way in which they deliver services the mental health centers are not effective in helping abusive families. Those who advocate treatment by the mental health centers point to the expertise in treatment techniques and to the high caseloads and low frequency of contacts between clients and public social service workers. The best argument in favor of these advocates against treatment by the public agency is the fact that in most agencies the caseloads are too high and the staff is untrained in treatment techniques. Thus, we are confronted with a situation in which, in most communities, no agency provides the treatment which is necessary and effective.
- There needs to be a coherent national policy as to where the treatment of abusive families belongs. If the consensus is that such treatment is the responsibility of the mental health centers, then the National Institute of Mental Health should issue guidelines as to effective practice, should make available case materials descriptive of different treatment processes, and should provide opportunities for training. Every mental health center should be encouraged to develop a child abuse treatment unit. The members of such a unit would receive training, would provide treatment, and would work closely with the public agency.

Day Care Centers/Schools

- All such institutions should have at least one person trained in identification who can provide support and consultation to others in the system.
- Day care centers and schools should have a relationship with protective services so that they can plan jointly with respect to certain cases. Abused and neglected children require a great deal of nurturance, support, and understanding; the school can respond to these needs if included in case planning. Day care, Head Start, and school nurses

can be particularly supportive of a protective services effort to monitor and improve the health of the children in a family.

Law Enforcement Systems

- Regardless of whether or not the police represent the only agency which has the legal authority to remove an endangered child from his home, they play a central role in most communities. In many cases of intrafamily violence which result in child abuse, the police are the first to be called. A high level of training and awareness on the part of the police can mean the difference between life and death for a child; similarly their attitude toward the parents can mean the difference between the parents' willingness to accept help and their view of all outsiders as the enemy.
- Juvenile court judges play a central role in abuse and neglect cases. An informed judge understands the points of view and professional biases represented by all of the key actors and is able to provide the leadership which is necessary for a therapeutic use of the court. The court can monitor whether all of the agencies and the parents have carried out the conditions of an agreement and ultimately the court decides the fate of the child. Informed judges who have received training in child abuse and neglect cases are a major resource in any community in which they exist. All too often, juvenile court judges have not had any training in this area, are parents' rights oriented, and have no understanding of the therapeutic value of the court.

- Any abuse program, no matter what the auspice, should maintain close collaborative ties with the police and the juvenile court. This collaboration should include joint training and discussions to ensure mutual understanding of objectives and intentions. An atmosphere of mutual respect and confidence can be engendered if representatives from each agency understand the responsibilities and work of those in the other agencies. This means, for instance, that the abuse program has to know how to present cases in court in order to ensure relevance and adequacy of data, while the juvenile court has to be informed about abusive families in order to make decisions which are maximally productive.

All of the agencies discussed in the preceding section have a role to play in the delivery and provision of services to abusive and neglectful families. Every community should have a child abuse and neglect council or committee which seeks to coordinate and upgrade existing services, which advocates for the development of new services, and which takes responsibility for public and professional education. Such committees can effectively bring problems to the attention of participating agencies, can alert administrators within these agencies to areas of poor practice and to areas of needed improvement, and can advocate for a child abuse team, and for training within each agency.

In rural areas, if the service agencies cover several communities or even counties, then the council should follow the catchment area of the agencies in deciding on its area of responsibility. Agencies serving abusive and neglectful families in rural areas are subject to the same problems which are endemic to health and social service agencies in rural areas: distance, difficulty recruiting qualified staff, and scarcity of resources. The scarcity of resources and difficulty of recruiting trained staff make the team approach especially important in rural areas. When all of the agencies pool their resources, there may be an adequate case management and treatment capability in the team itself. The team can also ensure that several members get training which they are then responsible for bringing back to the rest of the team. In this way scarce resources can be shared effectively. Scarcity of staff makes a lay therapy, parent aide, or volunteer program especially attractive. The need to drive long distances to see families imposes a requirement of smaller caseloads and this, too, suggests the importance of volunteers in rural areas.

In large urban centers, the complexity and variety of resources available may require regionalization of the child abuse and neglect committee within the city if the community is to avoid the diffusion borne of large size and nonarea specific problems. Each area of the city should have its own committee with representation from those public social service and public health agencies, hospitals, school districts, and police precincts which serve that area.

The central issue is one of ensuring that every relevant agency is alert to the possibility of abuse and neglect, is clear about the mechanisms of reporting cases and of dealing honestly and sensitively with families to be reported, and delivers the services which the community has assigned to it in a responsible and effective manner. As we have discussed, staff in all relevant agencies need training and an identifiable person(s) with primary responsibility in this area. Reporting increases and outcomes, as measured by recidivism rates, improve when all of the agencies are doing their job.

RECOMMENDATIONS TO NIMH

Of all the agencies, perhaps the greatest discrepancy between the potential to provide help to these families and actual practice lies in the community mental health centers. Every mental health center should have a specialized capability for treating abusive families which includes certain essential elements.

- Each mental health center should have at least two staff members who have received intensive training in the problems and treatment of abuse; one of these should be an individual who works primarily with adults and who has experience as a group and family therapist and one should be an individual who works primarily with children. It should be apparent that in larger mental health centers the size of the special abuse staff should be increased.
- Each center should have at least one ongoing therapy group for adults for which the mental health center has primary responsibility but which includes a protective services worker and at least one ongoing therapy group for abused adolescents which, through linkages with day care or Head Start, includes opportunities to practice a different kind of parenting.
- Each center should have a demonstrated capability for working with clients in their own homes, at least in the first few months of treatment, and a demonstrated capability of following up on every missed appointment by an abusive parent.
- The child abuse team within the mental health center should hold a weekly case conference for the purpose of sharing cases and treatment skills with colleagues, for the purpose of providing training to colleagues within the mental health center who might be encouraged to work with abusive families, and for the purpose of providing training and sharing information with protective services staff. Participants in these case conferences should include the team within the mental health center, other interested mental health staff, several protective services workers who may be assigned on a 1-year basis as a training experience, and the protective services worker whose particular case is being addressed.
- Finally, one of the members of the team should participate on the community child abuse and neglect committee and should bring back the concerns of the committee regarding improvements in services to the mental health center and it administrative staff.

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